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ABSTRACT

This manual brings current knowledge about the needs of abused and neglected children together with practical ideas about what can be done to meet those needs. Designed primarily for use by child protective service (CPS) workers, the manual may also be used by other professionals dealing with child abuse and neglect. Chapter 1 briefly discusses abused and neglected children's needs for treatment, recommending that CPS workers acquire the ability to assess children's needs. Chapter 2 provides general guidelines for getting immediate medical evaluation for suspected cases of maltreatment, while chapter 3 alerts CPS workers to the likelihood that the abused or neglected child will need treatment for medical problems other than the obvious ones. Chapter 4 describes alternate possibilities for providing a safe place for the maltreated child to live. In chapters 5 and 6, approaches for treating developmental and psychological problems are discussed. Intervention in the home environment is discussed in chapter 7, while chapter 8 points out potential harmful effects of treatment. Contents of the manual are summarized in chapter 9, and tests used to assess development, speech, and language are appended. (RH)

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TREATMENT

FOR ABUSED AND NEGLECTED CHILDREN

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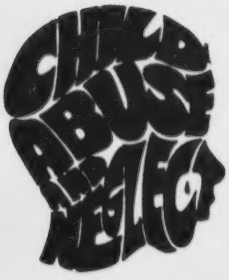

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FOR ABUSED AND NEGLECTED CHILDREN

Harold P. Martin

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TABLE OF CONTENTS

	Page
PREFACE	
I. NEED FOR TREATMENT OF ABUSED AND NEGLECTED CHILDREN	1
CPS Involvement in the Treatment of Abused and Neglected Children	1
II. TREATMENT OF MEDICAL TRAUMA OF MALTREATMENT	4
Need for Immediate Medical Evaluation	4
Where to Take the Child	5
Medical Inexperience and Resistance	6
What Will Be Done	7
Evaluation of Injuries	7
Suspicious Injuries	7
Medical Evaluation	8
Documentation	10
Follow-up Medical Treatment	10
III. TREATMENT OF OTHER MEDICAL PROBLEMS	11
Common Medical Problems	11
Inadequate Immunization	11
Hearing Deficits	11
Anemia	13
Inadequate Growth or Nutrition	13
Head Circumference Should Be Measured and Plotted	16
Infection	17
Hygiene	17
Dental Health	17
Vision	17
Congenital Anomalies	17
Previous High-Risk Factors	18
Ongoing Medical Care	18

Table of Contents

(continued)

	Page
IV. A SAFE PLACE TO LIVE	20
Alternate Care	20
Child in Biologic Home with Supervision from Child Protective Services	20
Homemaker Services	21
Parent Aides	21
Part-Time Alternate Care	21
Hospitalization	22
Foster Care	22
Appropriate Use of Foster Care	22
Residential Care	24
Residential Family Care	24
Adoption	24
Making Alternate Care More Therapeutic	26
V. TREATMENT OF DEVELOPMENTAL PROBLEMS	27
Assessment/Screening	28
When to Screen	28
Screening Mechanisms	28
History	29
Observation of Child	29
Checklist of Milestones	30
Formal Screening	30
Use of Other Agency Data	33
Clinical Intuition	35
Who Should Do the Screening	35
General Developmental Evaluation	36
Evaluation of Specific Developmental Delays	38

Table of Contents
(continued)

	Page
Treatment Modalities	39
Generalized Developmental Delays	39
Specific Therapies	42
VI. TREATMENT OF PSYCHOLOGICAL PROBLEMS	44
Assessment/Screening	45
Psychological Milestones	45
Developmental Stages	46
Symptoms	47
Consultation	48
Treatment Modalities	49
CPS Workers	49
Alternate Care	50
Therapeutic Consultation	50
Multidisciplinary Case Consultation Teams	51
Mental Health Therapy	52
Rationale for Treating the Emotional Needs of Maltreated Children	52
VII. CHANGING THE HOME ENVIRONMENT	53
Measurements of Parental Adequacy	53
Changes in the Parent	54
Changes in Parent-Child Interaction	55
Treatment of the Parent-Child Interaction	56
Parent-Child Visits	56
Home Visits	56
Parent Education	56
Parents' Groups	57
Family Therapy	57
Improving the Home Environment	57

Table of Contents

(continued)

	Page
VIII. HARMFUL EFFECTS OF TREATMENT	59
Methods for Avoiding Harmful Treatment Effects	60
Hospitalization	61
Separation From Parents	62
Separation and Loss	62
Changing Placements	64
Protracted Foster Care	65
The CPS Worker as Psychotherapeutic Agent	65
IX. SUMMARY	66
APPENDIX: TESTS USED TO ASSESS DEVELOPMENT, SPEECH AND LANGUAGE	A-1
BIBLIOGRAPHY	

LIST OF EXHIBITS

Exhibit		Page
I	Schedule For Immunizations	12
II	Developmental Milestones	31

PREFACE

Child abuse and neglect is a serious problem, resulting in the deaths of many children in the U.S each year. Even those children who survive abuse and neglect are likely to suffer permanent damage. According to conservative estimates, over 50% of maltreated children have serious developmental, psychological and medical problems, including learning disabilities, motor handicaps, and mental retardation. The price of being raised in an abusive or neglectful home is great. Further, the cost to society is frightening because maltreated children are likely to follow in the footsteps of their parents and require subsequent services for themselves and/or their children.

There is an unquestionable need to identify the consequences of growing up in an abusive or neglectful home and to make every attempt to modify those consequences. Maltreated children are being robbed of their childhood, of the opportunity to mature and develop in a healthy fashion. Professionals have an obligation to provide whatever services they can to remedy the problems of maltreated children. In the past, professionals have often concentrated their treatment efforts on the parents, hoping that the children would benefit as well. However, there are a variety of treatment services that are specifically beneficial to maltreated children, including day care, play therapy and therapeutic preschools, among others.

Unfortunately, many intervention strategies currently in use place additional stress on abused and neglected children. Because of a lack of treatment alternatives, maltreated children are often hospitalized, separated from their parents, and placed in homes with parent surrogates. The current foster care system does not allow foster parents to become real psychological parents to the child. Treatment providers must recognize the potential harm they cause children, the stress they place on children, and must do whatever they can to avoid such harmful effects.

Child protective (CPS) workers are in a pivotal position to address these problems and to identify maltreated children who are in need of further evaluation. They are one of the groups of professionals who can make a contribution by raising questions about the child's developmental, psychiatric and medical status, by noting maladaptive behaviors, and by recommending needed treatment for the child. CPS workers can assess the child and indicate the exact nature of concern regarding the child. They are in a unique position to help these children by ensuring that any actions that are taken are in the best interests of the child.

Treatment of Abused and Neglected Children is one in a series of manuals based on the *Federal Standards for Child Abuse and Neglect Prevention and Treatment Programs and Projects*. This manual brings together current knowledge about the needs of abused and neglected children with some practical ideas and explanations of what can be done to meet those needs. It is hoped that with this information, identification and treatment planning for maltreated children will be more efficient and effective. The manual is designed primarily for use by CPS workers, but may also be used by other professionals dealing with child abuse and neglect.

I

NEED FOR TREATMENT OF ABUSED AND NEGLECTED CHILDREN

In the past, protection from recurrent abuse or neglect has been the only service provided for abused and neglected children. Treatment for child maltreatment has focused on the family. Professionals have assumed that since the child has been in an unhealthy environment, the primary plan of action should be to change that environment. While it may be beneficial to the child to change the environment, focusing on this alone is not likely to meet all the child's needs. In addition, this assumption does not take into account that the environment may change very little, or may take years to become adequate.

In fact, abused and neglected children often have needs which can only be met outside of the family. Many of these children have needs that will not respond to improved parenting. In addition, although abusive and neglectful parents are often provided with a variety of services, such as employment counseling, financial aid, and psychotherapy, these services may not result in a change in their parenting patterns. Thus, it is possible for parents to improve their self-concept, obtain job training, work through a number of intrapsychic problems, and still not be able to change their deleterious parenting patterns.

The high rate of recurrence of abuse and neglect by parents who are receiving services has often resulted in the belief that placement outside of the biologic home is the treatment of choice. This, however, is not always in the best interests of the child. It is necessary for those working in the field of child abuse and neglect to explore more effective means of providing treatment to these parents. It is equally important to provide direct treatment for abused and neglected children.

CPS INVOLVEMENT IN THE TREATMENT OF ABUSED AND NEGLECTED CHILDREN

Child Protective Services has the legal mandate to protect children; they are responsible for the health and welfare of abused and neglected children. For this reason, CPS workers must assess the need for immediate medical treatment in abused and neglected children. In addition, CPS workers should be able to make some assessment of the child's developmental status, psychological state and nonemergency medical needs. CPS workers may resist making these kinds of assessments because of lack of time or adequate training.

There are, however, several critical reasons for assessing the child's status and treatment needs.

- Adequate Evaluation and Treatment Planning: Over 50% of abused and neglected children have significant developmental, psychological, and medical problems which need treatment. Treating these children requires more than just protecting them from subsequent injury. The CPS worker is in a unique position to identify those children who need developmental evaluation, those children who need psychiatric consultation, and those children who have medical needs beyond their immediate injury. The CPS worker is the professional responsible for obtaining needed consultation and developing a rational and necessary treatment plan to remediate these problems.

- Diagnosis and Evaluation of the Family: Children's developmental status and/or psychological characteristics can help in evaluating the home environment. In situations where information concerning an injury is not convincing, additional information on development, medical status,and personality can help in making professional judgments, diagnosis,and evaluation. In addition, information about the presence of developmental delays or maladaptive personality traits or unmet medical needs may affect the court's decision regarding an abuse and neglect petition.

- Assessment of Risk to the Child: CPS workers are required to make decisions regarding the risks to the child of remaining in or returning to his/her home. The severity of the physical injury to children is not an adequate measure of the harmfulness of the home environment. Even with a relatively minor injury (from the medical standpoint), a home may be considered quite dangerous and harmful to a child. A more valid determination can be made if the developmental and psychological status of the child is also considered. If the child seems developmentally and psychologically normal and does not have a number of previously unmet medical needs, then there is a smaller chance that the child has been repeatedly and continuously exposed to a

deleterious environment, regardless of the nature of the traumatic injury. Conversely, a grave developmental or psychiatric problem in the child will greatly influence the decision about the risk to the child in such a home, even if the injuries are rather minor. However, some children who experience maltreatment do not exhibit maladaptive behaviors because of coping skills which make them less vulnerable to harm.

- Role of the Child: There are instances where a child's role in the dynamics of abuse or neglect is considerable. There are families who can and do cope well with some children, while a particular child is abused or neglected. While there are a number of reasons why this occurs, one factor which has to be considered is whether the child in question is less gratifying, more difficult, or is deviant in some way. In such instances, it will be most helpful to document the special characteristics of the child (regardless of whether those characteristics are congenital or shaped by the home environment), so that one can better understand the dynamics of the maltreatment. Further, remediation of those characteristics, when possible, may make it more likely that the parents will be able to change their attitudes and behavior toward the child. In summary, it may be that a child whose hearing problem, visual deficit, or language delay is corrected may be at less risk of maltreatment. Even if the condition of the child is not correctable, identifying the characteristic may help in understanding why this particular child was maltreated in this particular family.

Thus, CPS workers can and should recognize and understand the treatment needs of abused and neglected children. Armed with the knowledge about the medical, psychological, and developmental needs and problems of abused children, the CPS worker can be effective in identifying and arranging treatment for these children.

II

TREATMENT OF MEDICAL TRAUMA OF MALTREATMENT

When a child is suspected of having been abused or physically neglected, a medical examination is necessary. This examination can: 1) help to confirm whether there is a nonaccidental injury(s) or substantive physical neglect, 2) assist in planning treatment for injuries or for the neglected state of the child, and 3) determine if there are medical problems which are not suspected by the CPS worker. It is important to note that the physical state of the child who is suspected of having been abused or neglected may be the result of medical problems not related to the suspected maltreatment.

CPS workers should remember that the physical indicators of abuse or neglect alone are not sufficient to substantiate suspected abuse or neglect. It is essential that they take into account such factors as the parents' explanation of the child's injury(s), the child's explanation, parent-child interaction and the physical condition of the home.

NEED FOR IMMEDIATE MEDICAL EVALUATION

Immediate medical evaluation is necessary when any of the following conditions are present:

- Any type of fracture in a child
- Head injuries
- Serious infections
- Serious burns
- Severe bruising
- Sexual abuse
- Failure-to-thrive
- Unattended medical problems, for example, high fever or difficulty in breathing.

WHERE TO TAKE THE CHILD

The local agency may have policies as to where children with suspected abuse or neglect are taken for medical evaluation. Assuming this is not the case, the following guidelines should be considered.

- If the child has been seen or followed by a particular physician or clinic in the past, this medical resource will offer advantages over having the child seen by a physician or nurse who has never examined the child before. A physician's knowledge of the child's previous state of health and physical condition will make the current examination more valid and helpful. Further, the child is apt to be less fearful if examined by a physician who is not a stranger. This is not a viable option if the family is reluctant to identify injuries as the result of abuse or neglect.

- If there is no physician available who has had prior experience with the child in question, the CPS workers should consider a medical facility where the staff has experience and expertise in coping with trauma. Generally, this will be a hospital. Hospitals which have an active 24-hour emergency room staffed by in-house physicians (staff or trainees) are, on the whole, experienced in diagnosing and treating trauma of various types. Further, they should have experience in dealing with suspected nonaccidental trauma.

- When neither of these is available, the CPS agency may know of certain physicians in the community who are particularly knowledgeable and cooperative in seeing abused/neglected children and working with the social agencies.

- In most instances, the child should be taken to a facility where X-ray examination and laboratory workup can be done if it is indicated. Further, since the child may need to be hospitalized for observation or further evaluation,

a hospital out-patient department or emergency room has advantages over taking the child to a private office. This latter plan should only be considered if laboratory and radiologic facilities are available there. There are times when the injury is quite mild from a medical viewpoint. Nonetheless, such a child will often require skeletal X-rays or other tests which are frequently not available in a private office. Thus, in most instances, the child should be seen in a hospital or other facility where such resources are available.

- A few abused children will need to be hospitalized for observation or treatment. If there is any choice in the community, it is preferable to take the child to a hospital that has a pediatric ward, rather than a general hospital where there is no special area for children. Hospitals with a pediatric ward will have nurses and technicians who are specially trained and committed to child patients. The child is not as apt to be treated as a small adult, and the special needs and procedures for children are understood and respected.

Medical Inexperience and Resistance

Many times, the physician who is examining the child will not be experienced in the special issues related to suspected abuse and neglect. This may be especially true if the physician is an intern or resident. However, any physician, regardless of age or experience, may be uncomfortable in dealing with this emotionally laden issue. Fears of invalid accusation of maltreatment, concern with the future need for court appearance, or personal anger at seeing a battered child may work to make the physician less objective and competent in evaluating such children. CPS workers can help the physician conduct a complete and adequate evaluation through suggestions and subtle questions. For instance, CPS workers might ask, "Do you think that we might want a skeletal survey to make sure that there aren't any old and healing fractures?" Or they might suggest, "You know, doctor, if this child has been physically abused and the case comes to court, either you or I may be asked by the parents' attorney if the bruises the child has could be due to a bleeding disorder. We've found that it is very helpful in such instances to have had a bleeding workup done to be able to answer such a question." Many physicians will be grateful for such suggestions and hints, if they are offered in a helpful and diplomatic fashion.

When CPS workers take a child for a medical evaluation, they have the right and obligation to know that the child is receiving adequate care. While some physicians will be indignant at any "interference," CPS workers should persevere in overseeing the medical care the child receives.

WHAT WILL BE DONE

In cases where it has been determined that a medical evaluation is needed, a *complete* physical examination should be performed. The physician will also want a complete medical history, although this is often not possible if the parents are unavailable or uncooperative. The medical staff must give priority to the child's serious medical injuries; however, the physician should not deal exclusively with these serious injuries and fail to perform a complete examination, as other injuries or signs of neglect may exist.

Evaluation of Injuries

The examining physician needs to carefully evaluate the injuries and wounds of the child, as well as document in writing the details of the injuries. The purposes of this exacting examination are to:

- give medical personnel adequate evaluation for treatment
- determine if the injuries are indicative of nonaccidental trauma
- document the size, location, and timing of the injuries for potential use in court at a later time.

Suspicious Injuries

In some cases, the injuries or the circumstances surrounding the injury may give the physician and the CPS worker a reasonable suspicion that abuse or neglect has occurred. For example, the nature of the injuries may not be consistent with the history given. For instance, falls from a couch or bed do not usually result in skull fractures or multiple bruises. Falls usually only cause bruises on one surface of the body, usually on bony prominences. Skulls do not fracture easily, certainly not from a baby rolling from bed to carpeted floor.

Bruises, welts, burns and other marks on the skin are often suggestive of, if not outright diagnostic signs of, inflicted injury. Marks may be fingertip in size and distribution, lesions may be mostly on the lower back (which is rarely accidental), or burns may be distributed in a pattern which cannot be accounted for by the history. Scars and marks from cigarette burns, straps, belt buckles, and cords are fairly easily recognizable.

Epiphyseal or metaphyseal injuries are usually due to twisting, jerking, or pulling incidents. At the end of long bones is a bony plate called the metaphysis, beyond which is the developing cartilage, the epiphysis. Twisting or pulling injuries often separate the epiphysis from the metaphysis, causing a chip fracture. Trauma, which may not cause a break in the bone, may lead to bleeding under the periosteum, a thin envelope which covers the outside of bones. After seven to fourteen days, the blood between the bone and the covering periosteum will start to show up on an X-ray as calcium begins to be deposited.

CPS workers may need to help the examining physician by raising questions or giving suggestions as to the possible basis for an injury. Thus, it is important for CPS workers to have knowledge of suspicious injuries.

Medical Evaluation

In addition to a physical examination, a child's injuries can be evaluated by X-rays, laboratory tests, and hospitalization for observation.

- When nonaccidental injury is suspected, the child will usually need a series of X-rays (a skeletal survey) to see if there are any current or healing fractures. This survey will usually include X-rays of the four extremities, the chest, and the head. This is especially needed in children too young to describe where they hurt, or too frightened to reveal past injuries (under five years of age is a good rule of thumb).

- If there are signs of bleeding or bruising, the physician should obtain laboratory tests to ascertain whether the child has a bleeding disorder. If and when the case comes to court, the CPS worker and physician may be asked to prove that bruises are not due to some bleeding disorder. The laboratory examination, while perhaps not needed from a strictly medical position, will be needed to assure the court that the child's bruises were not due to a medical disease, but were present because of injuries. Bleeding disorders which might only show up through bruises are very uncommon, but they must be ruled out. However, the physician must consider the discomfort and possible trauma to the child when determining whether to conduct laboratory tests.

- The child may require hospitalization for observation, for treatment, or for the physician and CPS agency to buy 24 to 48 hours of time to assess the family. If there are no medical indications for hospitalization, and the CPS worker needs the child to be in a safe place for 24 to 48 hours for a thorough evaluation of the family, emergency foster care placement is preferable to hospitalization. The choice between these two options will largely depend on local resources and attitudes. However, when no medical indications suggest hospitalization, CPS workers should be aware of the disadvantages of hospitalization over a home setting. In a hospital, a child is exposed to contagious diseases, the adult caretakers change shifts every eight hours, and the cost is much higher than a foster care placement.

Hidden Injuries: During the medical evaluation, physicians must be careful to check for hidden or unsuspected injuries. The following are examples of such injuries.

- Injuries about the genitals and anal region can easily be overlooked, as well as scars from cigarette burns anywhere over the body. Therefore the child should be completely undressed at some point. In addition, signs of injury under the hair should not be overlooked.

- Brain injury can occur from the shaking of young infants, where no external signs of injury are present. Thus, a neurological examination is indicated in all abused children.

- A fundoscopic examination (looking into the eye to inspect the retina, lens, and fluid content) should be included inasmuch as hemorrhages in the retina of the eye may be present with no external signs of injury.

- Some bone injuries may not show up on the initial X-rays. A reexamination by X-ray of any points of bone tenderness should be conducted seven to fourteen days later. It may only be at that point that the radiographs will show bone damage.

- It is important to examine the mouth, because tears and bruises are common under the tongue and on the inside of the cheeks.

Documentation

Medical personnel need to describe the injury in great detail. Most injuries can be dated as to when the trauma occurred. Bruises can be dated by their color, bone injuries by the phase of healing on X-rays, and burns and other wounds by their appearance. Multiple or repeated injuries at various times are common in maltreated children, and the medical evidence may be most helpful in pointing this out. Further, the date when the wound must have occurred may be inconsistent with the history the parents give. For instance, it is clear that a yellowing bruise could not have been incurred the day before the examination.

Injuries should be measured and their exact size recorded in the chart, along with other characteristics. Color photographs will often be most helpful if the case comes to court.

CPS workers who take the child to the physician can be helpful to the doctor and the child by suggesting that the diameter, color, distribution and other characteristics of the injuries be noted and recorded.

There are numerous places where the medical evaluation of non-accidental trauma is described. Suggested articles and books are noted in the bibliography.

Follow-up Medical Treatment

The CPS worker and the examining physician should make plans for follow-up treatment for the child's medical problems before the child leaves the medical facility. It is important that concern with the identification of abuse or the immediate treatment of an injury does not result in overlooking the need for medical follow-up.

III

TREATMENT OF OTHER MEDICAL PROBLEMS

Children who are abused or neglected frequently have had inadequate medical care in the past; the family may have neglected the child's hygiene, well-child care, nutrition, and illnesses. After the immediate medical wounds of the child have been treated and abuse or neglect has been substantiated, CPS should be prepared to have a number of medical issues identified and treated in the abused or neglected child.

COMMON MEDICAL PROBLEMS

CPS workers should be aware of the following medical problems which are commonly seen in abused and neglected children, because they may be responsible for obtaining medical care for the child or may need to assist the parents or caretaker in seeking medical attention.

Inadequate Immunization

Many neglected and abused children are delinquent in their immunizations. CPS workers should obtain information regarding previous immunizations from the parents and/or health facilities. If immunizations are delinquent or incomplete, they should be brought up to date. The exhibit following this page describes the recommended schedule for routine immunizations in children, and a schedule that should be followed when the child has never been immunized.

CPS workers or caretakers should request information from the nurse or physician giving the immunizations regarding expected reactions and contraindications to immunizations.

Hearing Deficits

Mild hearing problems are frequently found in abused and neglected children. The most common reason for a mild hearing loss is unattended or inadequately treated ear infections. When a child has an ear infection, there is usually an accumulation of fluid behind the ear drum which interferes with the transmission of sound. Even when the infection itself is gone, the fluid may remain and impede good sound transmission. This results in a "conductive" hearing loss. Mild conductive hearing losses may be too subtle to identify in a casual assessment. The examining physician may not identify this if the child appears to hear adequately during the examination. A formal hearing assessment should be considered when:

Exhibit I

SCHEDULE FOR IMMUNIZATIONS

Recommended schedule for routine immunizations in children.

2 months age	DPT* and Oral Polio
4 months age	DPT* and Oral Polio
6 months age	DPT* and Oral Polio
18 months age	DPT* and Oral Polio boosters, measles, mumps, and rubella shot
4-6 years age	DPT* and Oral Polio boosters
14-16 years age	DT** Booster

Recommended schedule for the child who has never been immunized.

Initial Immunizations	DPT* and Oral Polio (use DT** instead of DPT if child is over 6 years)
1 month later	Measles, mumps, and rubella
2 months later	DPT* & Oral Polio (use DT** instead of DPT if child is over 6 years)
4 months later	DPT* (omit this in the child over 6 years)
6-12 months later	DPT* & Oral Polio (use DT** instead of DPT if child is over 6 years)
14-16 years age	DT**
Every 10 years thereafter	DT**

*DPT: immunization for Diphtheria, Pertussis (whooping cough) and Tetanus

**DT: immunization for Diphtheria and Tetanus (Pertussis not given after 6 years of age)

- the child has a history of frequent ear infections
- the child does not appear responsive to sounds
- the child's speech and language are delayed
- the child's articulation is poor for his/her age.

When any of these four conditions exist, the CPS worker or caretaker should inquire as to whether the physician is sure that the child's hearing is normal, and whether a hearing test should be considered.

Anemia

Research has shown that abused and neglected children are likely to be at high risk for anemia and/or have lower levels of hemoglobin than other children. The anemia most often seen in maltreated children is due to inadequate oral intake of iron-containing foods (largely meat and eggs). For example, CPS workers should be alert for "milk babies," babies who have received only milk with no other types of food. These babies usually appear to be pale and fat because of their high calorie intake, but they may be anemic because of the lack of other foods in their diet. This is especially common in neglected children. If the physician makes no comment as to the child's hemoglobin or hematocrit levels, the CPS worker or caretaker would be advised to inquire as to whether the child is anemic or not.

If children are found to be iron deficient and anemic, the usual treatment is to assure that they have a diet including foods with high iron content. If the anemia is severe, an iron supplement (found at any drug counter) may be prescribed. Blood transfusion is only rarely indicated in children who have lost blood through hemorrhage or who are severely and critically anemic for other reasons.

Inadequate Growth or Nutrition

Poor growth of the child may be the primary reason for suspecting neglect. If the child's weight or height is quite below standard, the child may be brought to the attention of CPS as a possible case of failure-to-thrive. However, in as many instances, the child's presenting problem is a nonaccidental injury, and coincidentally poor growth parameters are noted. Indeed, up to 30% of abused children exhibit growth failure at the time of identification of abuse. If the child's height or weight is below the third percentile on a growth chart, such information should be noted in the record.

When a child's weight or height is said to be below the third percentile, this means that 97% of the children that age have weights or heights which are greater. No particular percentile has any special magic about it. All that is being said is that only 3% (or 5% if at the fifth percentile) of children have measurements as low or lower. While these specific percentile rankings are often used to suggest that the child's size is small and needs investigation, the *rate of growth* of a child is just as important to note. For instance, if a child's rate of growth has slowed significantly, for example, if a child has been growing so that his/her measurements had consistently been at the 75th percentile and then suddenly slowed so that the height and weight were now at the 10th or 25th percentile, this decrease in *rate* of growth would be just as significant as a child who started out at the 40th percentile and is now below the third percentile.

One of the practical implications for the CPS worker is to obtain previous measurements of the child and plot them on a growth chart. This chart could be included in the case record, and is especially important in the case of a child with a presenting problem of failure-to-thrive. Indeed, this should routinely be done on all failure-to-thrive children. It will be helpful in the abused child also. Previous measurements of height, weight, and head circumference, from birth up to the present, can usually be obtained from any physician or clinic where the child has previously been seen. If the child is in the parents' custody, CPS workers must involve the parents in this process. In order to obtain this kind of information from a physician, CPS workers must have the parents sign a consent for release of information.

Growth charts are available from health clinics or from pharmaceutical companies which make products for babies (especially the companies which make baby formulas). CPS workers can call a druggist and obtain the name and phone number of a local representative of one of the companies making baby formulas and ask for a free supply of these growth charts. The plotted growth charts can be very helpful in assessment of the child and in monitoring progress after treatment. CPS workers can use this while working with the parents in helping them to assess their child's growth and development. In some court hearings, these charts may be entered as medical evidence.

There are several reasons for inadequate physical growth and development. The child may be receiving inadequate food intake (inadequate calories being offered to the child). The child may be living in a poor home environment where there is a lack of physical, emotional, and/or intellectual stimulation. CPS workers must take into account

both the nutritional and environmental factors and must also remember that there are a number of less common medical diseases and conditions which can result in such low weight gain. If the child is seriously undernourished, the physician will want the child hospitalized. The following are two types of action open to the physician.

- The physician may wish to run a battery of tests to rule out any medical condition which might be causing the undernourished state. These tests will be directed at identifying metabolic disease, an endocrine problem, such as poor thyroid function, or a difficulty in absorption of food stuffs. There may be some specific reason indicated in the history or in examination of the child to point to the possibility of some other medical problem. Alternately, even without any reason to suspect such problems, some physicians will want to rule them out through extensive laboratory testing.

- A second and preferable course of action is to conduct only the routine laboratory tests done on all patients entering the hospital, and not to conduct the more extensive laboratory tests until it is determined whether the child will start gaining weight when offered a normal diet. Most children who have failed to thrive because of inadequate calorie intake will show remarkable gain in weight in seven to ten days. Waiting to see if weight increases is usually done in the hospital; however, it could be done just as easily and perhaps preferably in a foster home. As indicated previously, a hospital is not the ideal place for children if there are no medical indications. Further, the emotional stress of hospitalization may preclude the child gaining weight as quickly as might be true in a substitute home. Finally, undernourished children frequently contract respiratory or intestinal infections in hospitals which inhibit appetite and interfere with growth, making the diagnostic trial of normal diet more difficult to assess.

The CPS worker, biologic parent, or caretaker, should know what the physician's plans are regarding an evaluation of poor weight or low stature. When the child's weight can be shown to rapidly accelerate with only normal diet and a substitute environment (hospital or foster care), this is convincing legal evidence of nutritional neglect in the biologic home.

Head Circumference Should Be Measured and Plotted

This can and should be done by the physician or nurse tending the child, but it is frequently overlooked. CPS workers would be well advised to ask the physician or nurse what the head circumference is and where it falls on the growth chart. It is a simple measurement to obtain. A measuring tape is used to note the largest circumference of the head of the child, and usually two or three measurements are taken to assure obtaining the largest one. The measurement in inches or centimeters can then be charted against standards. Most growth charts have normal standards for weight, height, and head circumference.

Growth of the skull is governed by different forces than govern the growth of the other bones of the body like the spine or legs. The most important factor which causes the head of the infant and young child to grow is the *growth of the brain*. So, if the brain is not growing at an adequate rate, neither will the skull, and the head circumference will be small. Similarly, if the contents of the skull are growing too fast (as in the case of accumulation of fluid from hydrocephalus), the head may be large due to pressure on the skull.

The most common concern in maltreated children is the small head, commonly called microcephaly. This term is used for a head which is quite small; definitions of this vary, but it is usually used when the head circumference is two or more standard deviations below the average (or when it is below the third percentile). Just as with height and weight, the *rate* of head growth is more important than the absolute measurement at any one point.

Microcephaly was thought to be a sign of mental retardation, but this is *not* always the case. Further, in the very young child, microcephaly may be reversible. Especially in the undernourished child with microcephaly, institution of adequate nutrition may be accompanied by an increase in head growth, sometimes to the point where the head size will reach the normal range. This is an especially important reason for measuring and charting the head circumference when the child is first seen, and using subsequent measurements for following an indirect measurement of brain growth. It must be emphasized that, while most children with significantly small heads have retarded development, not all are retarded and so this finding cannot be used to diagnose or prove retardation.

Infection

Some workers are impressed that abused and neglected children have more infections than other children. The examining physician will be looking for signs of low grade infection or indications of past infection. As noted above, one common area for this to be found is in the middle ear. The physician may:

- prescribe antibiotics if active infection is present
- prescribe a decongestant if there is fluid behind the ear drum and no current active infection
- do a myringotomy (making a hole in the ear drum) or place tubes through the ear drum if the fluid does not disappear with the use of medicines.

Hygiene

Little need be said here other than to note that the maltreated child is more apt to have signs of inadequate hygiene, such as diaper rash, impetigo, cradle cap, lice, or scabies.

Dental Health

Approximately 40% to 50% of physically abused children suffer trauma about the face and mouth. This is particularly common in infants and small children; a crying or screaming child is often hit in the mouth. The signs of neglect of the mouth are sometimes more subtle. However, cavities and gingivitis are common in children who experience nutritional and/or physical neglect. An oral examination is indicated to determine if dental hygiene has been neglected and if the child requires dental work.

Vision

While impaired vision is not common in maltreated children, some assessment of visual acuity should be undertaken. This may only require informal assessment in the infant or young child, or in the older child,screening by the Snellen or illiterate E chart.

Congenital Anomalies

A congenital anomaly is an anatomical abnormality that is present at birth. Congenital anomalies can be major, for example heart disease or a hair lip, or minor, such as abnormal finger or hand prints.

There is some disagreement as to whether children with congenital anomalies are at higher risk of abuse or neglect. While researchers have found different results, it is this author's position that children with congenital anomalies or disease states are at greater risk of neglect, although not at greater risk of abuse. Nonetheless, the conflicting data require a high index of suspicion for congenital anomalies in children who are abused or neglected. Many of these abnormalities may be insignificant and minor, requiring no specific treatment, for example, low set ears, curved fifth finger, or wide-set eyes. However, anomalies of the heart, kidney, or intestinal tract are more serious and may require specific treatment.

CPS workers might wish specifically to ask the examining physician if he/she found any signs of minor or major congenital anomalies. This may be important in determining if this child was more difficult to care for or more difficult to bond and attach to than an average child.

PREVIOUS HIGH-RISK FACTORS

CPS workers should obtain information as to the medical background of the child. They should be particularly concerned with whether the child was small at birth, whether there were medical problems in the newborn nursery, and finally whether the child had been unusually sickly during infancy and early childhood.

Most researchers have found that abused and neglected children are much more likely to have been prematurely born or to have been smaller at birth than the general population. While these early problems may no longer be affecting the child, the identification of early problems may help CPS workers determine if this is a child whose early life experiences made him/her a more difficult child for whom to care, or made him/her a child to whom it was more difficult to bond and attach. If this is the case, the approach to the biologic parents might be quite different.

ONGOING MEDICAL CARE

The CPS worker needs to arrange for or assist the parents in arranging for ongoing medical care for the child. Even if no special medical problems exist, the child will need to have periodic well-child checks. It is advisable to find a medical facility where the child will be seen and examined by the same physician or small group of physicians on subsequent visits. *It is to the disadvantage of any child, but especially abused or neglected children, to be seen by a different physician each time they have a medical examination.*

This may be arranged with a private physician, or a private group or clinic where an attempt is made to have continuity of care with a minimum of substitutions of physicians. Some city, county, or teaching hospitals have arrangements whereby people can be assigned to a single physician who will see them for routine appointments. Without this continuity of medical care, CPS workers will find it more difficult to monitor the child's health maintenance.

IV

A SAFE PLACE TO LIVE

After the immediate medical needs of the child are attended to, the second and most critically important treatment needed by the child is a safe place to live. While this manual will not deal in depth with the multiple issues involved in considering alternate care versus placement with biologic parents, a manual which addresses itself to the treatment needs of abused and neglected children cannot totally ignore this critical need. For detailed information concerning the assessment of risk to the child, readers are referred to another manual in this series entitled, *Child Protective Services: A Guide for Workers.*

When a child is first identified as potentially maltreated, CPS workers are required to make decisions regarding whether the home is safe or not, frequently without having much information about the family or natural environment of the child. In emergency situations, 24 to 48 hours of alternate care is often required to buy time to investigate the family and home of the child so as to make some decision as to whether that is a safe place for the child. The community must have plans for emergency placement. As indicated in a previous section, while medical issues may require hospitalization, more often this will not be the case, and foster homes must be available which can accept children on an emergency basis.

ALTERNATE CARE

After the initial investigation, CPS workers have gathered more information about the child and family. This information will assist in the long-term planning for the protection of the child. The most common options available are discussed in this section.

Child in Biologic Home with Supervision from Child Protective Services

Supervision of children in their biologic home by child protective services is preferable to any other options if the home is deemed safe and if adequate supervision can realistically be provided. It requires a treatment plan to minimize the chances of subsequent abuse or neglect. While this is considered to be ideal for the child, CPS workers cannot ignore the fact that large numbers of maltreated children suffer subsequent abuse in most communities. Homemaker services and parent aides can be used in conjunction with child protective supervision to maintain the child safely in the home.

Homemaker Services

Homemaker services can be used in a variety of ways in treating families experiencing abuse and neglect problems. They are especially helpful in maintaining the family unit because homemakers can move in on a temporary basis with families experiencing stress, thus providing an alternative to removing the child.

Homemakers are used primarily to help parents with home management and child care. They can also be trained to provide parents with understanding and emotional support.

Parent Aides

Parent aides are paraprofessionals who usually work on a voluntary basis with abusing and neglectful parents. Parent aides become intensely involved with parents, providing them with warmth, understanding, support and a listening ear. By providing this kind of nurturing relationship to abusive parents, the parent aides can help to reduce stress and can act as a vehicle for resolving family problems. For detailed information regarding the development and implementation of parent aide programs, readers should refer to another manual in this series entitled, *Parent Aides in Child Protective Services: Program Development and Implementation.*

Part-Time Alternate Care

Part-time alternate care allows children to live with their natural parents but have some periods of care outside of the home on a regular basis. This regularly scheduled alternate care might include a day care home or a preschool.

It is time to be more innovative in planning for the abused or neglected child. The biologic home may be a safe environment for the children if they spend several hours a day in a day care home or a preschool. With such an arrangement, parents have considerable respite from the day-to-day care of the child.

The alternate care facility may be specifically therapeutic for the child and will be discussed in a later chapter. With such an arrangement, the bonds between the child and parent need not be severed or weakened as is usually the case with full-time foster care. This type of plan for the child may also prevent recurrence of abuse or neglect. In addition, it allows for improvement in the parent-

child relationship because the parent has more access to the child than is usually possible when the child resides in a foster home.

Part-time alternate care is seldom considered; more frequent use could enable many maltreated children to remain with their parents.

Hospitalization

Hospital care is discussed in Chapter VIII. It is important to remember that hospital care is a poor living arrangement for any child who does not need specialized medical facilities, and it should be avoided when medical indications are absent.

Foster Care

Foster care is the most common alternative to home care utilized by CPS. It provides a home to children when the natural parents are unable or unwilling to provide adequate care. The legitimate use of foster care as a short-term, crisis-orented *adjunct* to treatment becomes highly questionable as the placement stretches into weeks, months, and years.

The turnover in foster homes, the questionable quality of many foster homes, and the trauma to children of being raised by "temporary" parents all speak to the importance of finding alternatives to long-term foster care.

Appropriate Use of Foster Care

The following are appropriate uses of foster care.

- Foster care can be used as a short-term living arrangement for children in emergency situations until an investigation of the family and home can be made and a treatment plan established.

- Foster care can be used diagnostically. When necessary, children may be placed in foster care to see if their physical growth (weight or height) or their developmental progress may accelerate. This may be the only way to determine that the child's developmental delays or inadequate growth are secondary to his/her natural environment. This usually takes only two weeks in the case of inadequate physical growth, and rarely need take more than six months when developmental progress needs to be assessed.

- Foster care may occasionally be used as a *therapeutic* milieu for the child for an extended period. This assumes that the foster home provides something especially beneficial for the child. This use is *not* a holding action, a way to provide some place for the child to live until he can be returned to parents or placed for adoption. This use of foster care as a *therapy* requires that the foster parents are trained and supported in being therapeutic agents for a child. If this approach is used, foster parents should be specially selected and enrolled in an intensive training program. In addition, it is possible that in the future these foster parents could work with the natural parents to develop a therapeutic alliance. This, however, would not relieve CPS or foster care workers of the responsibility for arranging visits and working with the family in order to reunite them.

Foster care is only appropriate if it is part of permanent planning for the child. A well structured treatment plan should be instituted immediately after the placement of the child. This provides the parents with information regarding what is expected of them within a particular time frame, what professionals will be working with them, and what services will be provided in order to facilitate the return of their child. If treatment efforts are unsuccessful, the plan allows CPS workers to document their efforts and the parents' response to treatment. This documentation can be used either as a justification for modification of treatment approaches or for termination of the parents' rights so that the child can be placed for adoption. For detailed information regarding permanent planning, readers are referred to *Permanent Planning For Children in Foster Care: A Handbook for Social Workers*, DHEW Publication No. (OHDS) 77-30124.

Foster care is unacceptable when:

- It is intended only to provide a substitute home for a long-term period, especially for very young children. While communities may not have many other options, it is suggested that alternate care plans must be developed if the best interests of the child are to be served.

- The foster care plan is not reviewed at least every six months.

Residential Care

There are two types of residential care relevant to abuse and neglect problems. One type of residential care is that which is used for the seriously disturbed or retarded child. The criteria for placing this type of child in a residential treatment facility are the same whether the child is maltreated or not.

These residential treatment facilities should provide each child with an advocate who would represent the child's interests and prevent incidents of institutional abuse or neglect. They should also develop and implement individualized treatment plans for each child which would be subject to review; they should encourage the family's participation in activities and in the decision-making process.

Residential care is only indicated when it can provide specialized treatment which is not available in the community. Special foster placement is preferable in almost all cases.

Residential Family Care

The second type of residential care is where the entire family moves into a therapeutic environment. This type of treatment modality is a mechanism for providing a safe environment for the child without severing the emotional bonds and attachments between child and parent. The National Center for Prevention and Treatment of Child Abuse and Neglect in Denver has had several years experience with residential treatment. Other agencies, such as the Family Stress Center in Pittsburgh and the New York Foundling Hospital, have also used modified versions of this type of treatment modality. This is a relatively new type of treatment and its usefulness and cost-effectiveness have not yet been documented.

Adoption

Adoption is an alternate care option which should be considered for some abused and neglected children. The following points should be taken into account.

- Adoption should be considered at the earliest possible stage when returning the child to the biological home is unwise or impossible. The practice of interminable foster care for maltreated children must be discontinued. The consequences to children of living in "temporary" quarters with "temporary" parent-surrogates are great. One researcher found that in a study of 624 foster children,

only 4.6% were adopted. Thirty-six percent of the children were still in foster care at the end of five years, and of those, 57% had not been visited by their parents. While many of the children were considered adoptable, only 16% of these potential adoptees were actually adopted. Further, *none* of the 22 abused and neglected children who were considered adoptable had been adopted over the five-year period.

This indicates the need for the initiation of treatment plans before a child has been placed in foster care with reviews every three to six months after placement.

- Standards should be developed which stipulate a time period after which the parents' rights are relinquished if the home is still considered unsafe for the child. These time periods should be dependent upon the age of the child. For example, developmental changes between birth and three years of age occur more quickly than at other stages. Thus, it is more crucial to consider adoption at an early stage with very young children. David Fanshel contends that children under one year should remain in foster care no longer than a year before adoption is arranged.*

- When an abused or neglected child is returned to the natural parents, the family will still require treatment services. In the same way, when a maltreated child is adopted, support must be given to the adoptive parents for an extended period of time. Abused and neglected children are at a higher risk of failed adoption than other children. This is especially true if the child has gone through the typical experience of having been in several foster homes prior to the adoption. Social and psychological consultation must be available to adoptive parents. This consultation should not only be available for

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* D. Fanshel of Columbia University School of Social Work in a presentation for Scholar Lecture Series, "Current Major Issues In the Field and a Look At the Future," sponsored by Program Development and Innovation Division of the Children's Bureau, January 31, 1979.

problems, but should be built into the adoptive process so that consultation can *prevent* problems from occurring or from escalating into insoluble crises. Since maltreated children are likely to need special developmental treatment, subsidized adoption should be available. This may include financial aid for special needs of the abused or neglected child, or this might be thought of as providing treatment and counseling to the child and the adoptive parents for an extended period of time after adoption takes place.

These provisions might well make adoption more attractive from the outset, and should decrease the chances of failed adoption. If help and support are offered to abusive and neglectful parents or to foster parents, why should they not be offered to adoptive parents?

MAKING ALTERNATE CARE MORE THERAPEUTIC

One of the critical treatment needs of the abused or neglected child is an immediate need for a safe place in which to live. This being of primary importance, any living arrangements which are unduly stressful (for example, hospitalizations) should be avoided unless there is no other choice. Children should not be placed in situations where the home and parent-surrogate will be changing frequently. Sometimes it is necessary to place children in foster care; in these cases every attempt should be made to make the foster care environment as therapeutic as possible. This can be accomplished through training foster parents and providing them with ongoing social and psychological consultation.

Whenever possible, attempts should be made to avoid the weakening of existent bonds and attachments between children and their natural parents, siblings, and other relatives. This goal can be reached either by placing children in part-time alternative care while they are living at home or by planning for liberal visitation while children are in foster care.

A place of safety is essential, but is not enough. Children need a place to live where they are safe. They also need a place to live which will help them grow and develop optimally. These needs are not mutually exclusive.

V

TREATMENT OF DEVELOPMENTAL PROBLEMS

The developmental consequences of being in an abusive or neglectful family are staggering. Conservative estimates indicate that over 50% of abused children will have significant developmental delays. It seems ironic that the developmental status of maltreated children is so often ignored, inasmuch as the frequency of problems in development is so common. Indeed, in one early report of what happens to abused children, one researcher noted that 88% of a group of abused children had problems at followup, including mental retardation, emotional disorders, serious speech problems, or marked physical defects.[1] Since that early report, others have noted serious delays in motor function, perceptual ability, and in academic learning skills.

It is not always clear why an abused child is delayed in some parameter of development. In some instances, it is clear that the delays are secondary to brain damage the child has suffered from the abuse or from medical and nutritional neglect. At other times, there may be no history of head injury and normal results upon neurologic examination, yet the function of the child's brain and nervous system is delayed or deviant. It is contended here that delays in speech and language, impairment of mental abilities, poorly developed motor skills, and impediments in learning can all be due to the environment in which the child has lived, even without biologic damage to the brain and nervous system.

It was established decades ago that children's development can be seriously retarded when the environment is lacking in stimulation and human caring. The earliest reports of this phenomenon dealt with children who were being raised in orphanages, foundling homes, prisons, and institutions. It was also noted that, in some instances, the retarded development could be altered through supplying the child with adequate stimulation and with a caring, loving mother-surrogate.

It did not take long to realize that children who were living in families could also suffer retarded development when there was inadequate parenting. While the perfect environment cannot be described, it is clear that children's development can be delayed when there are inadequate emotional support, minimal cognitive stimulation, disturbed parents, and constant danger of physical attack. Children will not learn to use speech and language if they are not spoken to, if there is no language for them to hear, model after, and respond

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[1]E. Elmer. *Children in Jeopardy*. Pittsburgh: University of Pittsburgh Press, 1967.

to. Children will not learn if the environment offers no reinforcement for performance, or if the environment punishes curiosity and investigativeness. A human infant needs a nurturing environment in which to grow. In order for children to develop, a certain amount of stimulation is required. Animal research and human experience show us that the developing nervous system requires a responsive environment for the organism to actualize its neuro-developmental potential.

Thus, a large percentage of maltreated children have developmental disabilities and delays. For the child's development to be corrected, an adequate family environment is required; perhaps it will require special remediation for the child to "catch up." These issues are addressed in the following sections.

ASSESSMENT/SCREENING

Given that over 50% of maltreated children will have significant developmental problems (the range is from 30% to 90% depending upon who is reporting), some plan of action needs to be undertaken by any CPS agency that sees more than a handful of maltreated children per year. The primary areas of development which are addressed here include mental abilities, speech and language, motor skills, and learning ability. The approach to identification of children with problems in each area will vary with the age of the child. It is up to CPS workers to screen the children in their caseload for developmental problems or to see to it that someone else screens these children.

When to Screen

Screening for developmental problems should ideally be done as early as possible. Initial screening will be helpful in determining a baseline of behavior. However, it is important to remember that the child's functioning may be greatly inhibited due to immediate stress. It is suggested, then, that the CPS worker give the child five to ten days to adapt to any significant stress, for example, hospitalization, trauma, separation from parents, and rescreen the child at this point. While even then it may not be possible to tap the *potential* of the child, this should come closer to an approximation of *typical* behavior of the child.

Screening Mechanisms

Screening children's development is simply a process of deciding whether it is likely or probable that a specific child has developmental problems of significance, or whether there is a greater

likelihood that the child is developing normally. Screening may be formal or informal. The following are ways professionals commonly make some screening judgment as to whether there are problems in the child's development.

History

An interview of a caretaker can usually give an accurate idea as to the normality of a child's development, assuming that the caretaker has spent enough time with the child to have had the opportunity to see the child's play, motor activity, problem solving, and speech and language patterns. Ideally, this is a parent or adult who has spent a long time with the child so that the caretaker can speak of past development as well as current functioning. It requires a caretaker who is a good historian. This is sometimes a problem with maltreated children, inasmuch as reports from abusing parents are usually unreliable as to the child's abilities and behavior. The CPS worker must make a judgment as to the dependability of the parent's history of development. Historical information can also be obtained from the child's teacher, day care workers, hospital nurse, or foster parent, if the person has had sufficient time to adequately assess the child's behavior.

This method of screening development requires the CPS worker to know what normal milestones of development are. It does no good to know that a 3 year old has a vocabulary of about ten words unless one knows whether this falls within normal limits or is excessively delayed. This issue of knowledge of normal milestones will be addressed subsequently.

At any rate, if the child's current developmental status is below age level, and especially if the child has a history of being slow in attaining developmental milestones in the past, the child should be considered at developmental risk and further, more elaborate developmental assessment should be arranged.

Observation of Child

An alternative to assessing a child's developmental status by history is for the CPS worker to observe the child. This requires the worker to have adequate time to observe the child when she/he is as relaxed and as natural as possible, for example, at play. If the worker knows what the normal behavior of children of different ages is, then observing the child in play and talking to

the older child may supply the worker with a fairly good idea as to the adequacy or normality of the child's motor skills, speech and language, and mental abilities. Again, this requires the worker to be familiar with normal developmental behavior of different ages.

Checklist of Milestones

By either of the methods noted above, the CPS worker needs a yardstick by which to measure the normality of a child's current or past behavior. Some CPS workers may have such a yardstick in their minds which can be used in assessing the development of children. However, many CPS workers would find it helpful to have some easily available written milestones to which to refer. There are countless such lists of normal developmental milestones which any CPS agency can make available to workers. Most such lists of expected behavior do not go beyond six years of age, assuming that school systems will identify children beyond that age if development is delayed.

Exhibit II, on pages 32 and 33, gives examples of behavior appropriate at various ages. It is important to remember that most milestones are placed at the age at which 50% or more of children can attain any particular task. Nonetheless, such a yardstick gives a general idea as to when children usually attain various milestones of development.

Formal Screening

There are a number of screening tests available, especially for the child under six years of age. (A list of some of the more common developmental tests is included in the Appendix.) Screening tests offer some important advantages over the more informal mechanisms of screening development that were discussed previously.

First, the use of a formal screening instrument can be less time consuming than taking a history, observing the child, and checking the child's behavior against normal developmental milestones. Secondly, a formal screening test offers the opportunity to see what a child can or does do in a standardized setting; that is, where the child is asked a question in exactly the same way that all other children are asked the same question or where the child's ability to perform some task (such as drawing a circle with a pencil) is graded or measured in exactly the same way as all other children's performances are measured and graded. Because of these advantages, the person performing the screening test has a better sense that the impressions as to the normality or deviance of the child's development are valid than when that judgment is based on more informal data such as history or casual observation.

Some screening tests offer other advantages. Many, for example, are broken out so that the child can be screened for motor, language, mental and social skills in one session. Furthermore, a test such as the Denver Developmental Screening Test (DDST) gives the examiner information not only as to when 50% of the children can attain a skill, but when 25%, 75%, and 90% of children attain the skill. Hence, the individual administering the test knows not only that 50% or more of children can walk alone by age 12 months, but also knows that 90% of children can do so by 14 months of age. With this information, then, the examiner might not become concerned when a 13 month old is not yet walking, but would be concerned by 15 months of age knowing that less than 10% of children are so delayed.

There are inherent problems in all screening tests, including the DDST. By necessity, there are always false negatives and false positives. That is, some children will pass such a test even though they have developmental problems of significance (a false negative); and some children who are perfectly normal in development will "fail" a screening test (a false positive). The better the screening instrument, the less frequent the false results. But because of the nature of screening tests, it is impossible to completely eliminate all false negatives or positives. It is also important to stress that *screening* tests are not *diagnostic* tests. A screening test suggests that a problem may exist, but it does not definitively identify the problem. The misuse or misinterpretation of screening results must be diligently avoided.

There are a host of developmental screening tests available. Although most CPS workers will not conduct developmental screening, they are quite capable of being *trained* to reliably administer, score, and interpret such tests. Further, there are materials available so that individuals can test themselves on their ability to reliably use these screening tests, as well as written and video-tape materials for self-instruction. The bibliography includes the address where screening test order forms and materials can be obtained.

A screening test such as the DDST has a manual accompanying it which offers the examiner guidelines as to when to refer a child for more exhaustive and comprehensive developmental assessment, and when to feel assured that there is little likelihood of significant developmental delay.

Use of Other Agency Data

Early childhood programs, such as preshcools, day care centers and Head Start Programs can provide information regarding a particular child's developmental status. Likewise, when the abused or neglected child is of school age (over five years of age), the school will

EXHIBIT II

DEVELOPMENTAL MILESTONES*

AGE	MOTOR	MENTAL	LANGUAGE	SOCIAL
3-6 months	will bear weight on legs can roll over stomach to back engages hands in midline when pulled to sit, head is steady, does not fall back when on abdomen, can lift shoulders off mat when on abdomen, can lift head and look about will begin to reach for and grasp objects sits with support	looks at objects in hand looks after a toy which is dropped uses a 2-hand approach to grasp toys looks at objects as small as a raisin turns head to voice, follows with eyes	coos gurgles chuckles laughs aloud squeals has expressive noises	has a social smile will pat a bottle with both hands anticipates food on sight
6-9 months	rolls from back to stomach gets feet to mouth sits alone, unsupported, for extended period (over 1 minute) stands with hands held on back, can lift head up beginning attempts to crawl or creep when sitting, reaches forward to grasp without falling	bangs toys in play transfers objects from hand to hand reaches for a toy with one hand picks up a toy he/she drops is persistent in obtaining toys would pull a toy to self by attached string	responds to name vocalizes to social stimulus has single consonants, i.e., ba, ka, ma combines syllables, i.e., da-da, ba-ba likes to make sounds with toys imitates sounds	expects repetition of stimulus likes frolicky play discriminates strangers smiles to mirror image takes some solid food to mouth bites and chews toys beginning to enjoy peekaboo
9-12 months	crawls well can sit steadily for more than 10 minutes stands holding on to furniture can pull to sitting position walks, holding on to a hand or to furniture	will uncover a toy he/she sees covered up can grasp object small as raisin with thumb and one finger beginning to put things in and out of containers goes for an object with index finger outstretched likes to drop objects deliberately shows interest in pictures	understands no, or inflection of "no!" uses mama, or dada, first inappropriately, then with meaning by 12 months has at least one other word knows meaning of 1-3 words	cooperates in games will try to roll ball to another person plays patacake and peekaboo waves goodbye will offer toy without releasing it likes to interact in play with adult
12-18 months	by 18 months, walks well alone creeps up stairs can get to standing position alone can stoop and recover an object walking, pulls a pull-toy seats self on chair	looks at pictures in a book will scribble spontaneously with pencil or crayon uses spoon drinks from cup will follow one or two directions, i.e., take a ball to ...	has 3-5 words will point to one body part will point to at least one picture uses jargon, i.e., unintelligible "foreign" language with inflection imitates some words	cooperates in dressing holds own bottle or cup finger feeds points or vocalizes to make desires known shows or offers a toy
18-24 months	can run, albeit stiffly walks up and down stairs with one hand held hurls a ball can kick a ball or object jumps with both feet stands on one foot with one hand held	can tower 2 or more 1 inch blocks turns pages of a book, even if 2-3 at a time will try to imitate what an adult draws with pencil can point to 2-3 body parts	by two years, has at least 20 words by two years, is combining two words in a phrase jargon, which was elaborate by 18 months, is gone by 24 months verbalizes desires with words	uses spoon, spilling very little removes one piece of clothing imitates housework more and more handles a cup quite well

*If child is not accomplishing two or three of these milestones, consider developmental consultation.

EXHIBIT II (Con'd)

AGE	MOTOR	MENTAL	LANGUAGE	SOCIAL
2-3 years	can walk up stairs without hand held can balance on one foot for one second can jump in place can walk on tiptoe can jump from the bottom step kicks ball forward can throw a ball	can tower 6 one inch blocks can dump a raisin from a bottle to attain without hints can imitate a vertical line, possibly a horizontal line, with pencil can anticipate the need to urinate or deficate if worked with, can toilet self	uses 2-4 word phrases uses plurals names at least one picture talks incessantly vocabulary 100-300 words by 3 years uses some personal pronouns, i.e., I, me, mine points to several parts of a doll on request identifies over 5 parts of own body	puts on some clothing washes and dries hands has parallel play with peers can pour from a pitcher
3-4 years	rides a tricycle alternates feet when going up stairs can stand on one foot for 2-5 seconds can broad jump uses scissors swings and climbs	can tower 8-10 one-inch blocks says full name can match colors has sense of round, square, and triangular shaped figures and can match them copies a circle, line, cross with pencil can repeat 3 digits	can answer some questions knows rhymes and songs asks questions has understanding of on, under, and behind	knows own sex beginning to play with other children unbuttons dresses with supervision
4-5 years	runs well and turns can hop on one foot 1-2 times beginning to skip stands on one leg for 10 seconds throws ball well overhand walks down stairs one foot to each step	can copy a cross with a pencil can pick the longer of two lines can copy a square with pencil	vocabulary over 1000 words can match colors, and by 5 years, name 3-4 colors counts 3 objects with pointing 90% of speech intelligible can define words in terms of use can answer questions like, what do you do when you are cold... hungry... tired....?	can separate from mother easily dresses with little supervision buttons likes to play "dramatic" play, make-believe imaginative play with a doll
5-6 years	skips on both feet alternately can catch a bounced ball can walk heel to toe on a line can hop on one foot for 10 feet	can copy a square or triangle from looking at a copy gives age knows morning from afternoon draws a person with a body, with 3-6 parts prints simple words	can repeat 4 digits asks questions about meaning of words counts 10 objects names coins can tell what some things are made of can define some words	no supervision necessary for dressing plays "dress-up" elaborate dramatic play does simple chores unattended at home

usually have very valuable data which can assist the CPS agency in deciding whether the child's development is in question, and whether further evaluation is indicated.

If the child's mental abilities, learning skills, or language are deficient, it will usually be identified by the school within one or two years of the child's entry into the school system. Typically, the child will then have had testing and evaluation by a school's special services personnel, minimally by a psychologist, and often by a language pathologist, special educator, and perhaps even a physical or occupational therapist. The school nurse or social worker may also have important data on the child. If the CPS agency has custody of the child, those data are freely available to the worker by contacting the school. Even without custody, signed permission from the legal parent or guardian can make that information available.

In situations where CPS does not have custody of a child and where the parents refuse to allow the school to release information, schools may be prohibited from releasing information to CPS because of the Federal Family Educational Rights and Privacy Act (FERPA) of 1974. There are exceptions however. For example, prior parental consent is not required when disclosing information from school records if a "health or safety emergency" exists; child abuse and neglect generally fits into this category. The responsibility for determining whether a "health or safety emergency" exists rests with school officials on a case by case basis. Another exception to the prior consent rule exists if the release of information contained in school records is made to:

> State and local officials or authorities to whom such information is specifically required to be disclosed pursuant to state statute adopted prior to November 19, 1974.

A final exception to the prior parental consent rule is provided in FERPA Section 99. This section provides that <u>any</u> information contained in a school record may be released without parental consent to

> comply with a judicial order or lawfully issued subpoena; Provided that . . . (the school) makes a reasonable effort to notify the parent . . . in advance of compliance.

It is strongly recommended that, whenever a school-aged child comes under the jurisdiction of CPS, school testing and records be obtained and used for evaluating the child's developmental status. Those records can become a part of the CPS file on such a child.

Clinical Intuition

It cannot be stressed too strongly that, even in the event of a normal history, screening tests, or previous evaluations, a child may still have significant developmental problems which have gone unnoted. At any point when the CPS worker feels that the child's development is deviant or delayed, even in the absence of corroborating formal data, the CPS worker should rely on clinical intuition and refer the child on for comprehensive developmental assessment. The history from the caretaker can be incorrect. Observation of the child might not have allowed the deviant or delayed development to be manifest. Screening tests, by design, must have some false results; some children with problems will be missed. Testing or evaluation by others may have missed the problems the CPS worker is noting. So when CPS workers feel that the child's intelligence, learning, language, or motor skills are not normal, they should obtain outside consultation.

Who Should Do the Screening

Ideally, screening of children's development should be done by a person who is experienced with children, has a knowledge of development, and is comfortable and expert in screening. This may be the child's physician or an attendant nurse. In some pediatric hospitals, there may be a screening technician or child care worker who can screen the child.

However, in many, if not most communities, it is going to fall to the CPS agency to do the screening or arrange for it to be done. It may well be the individual CPS worker who will need to screen the child's development. CPS workers need to be expert in children, in development, and in screening. CPS workers who carry many children on their caseloads will find assessment of development a rather interesting and challenging part of their job. It involves a set of skills and knowledge which can brighten up a frequently dreary workload. The CPS worker is, after all, functioning very much as a concerned surrogate parent. CPS workers are not only interested in the safety of the children in their caseloads; they are just as interested in the welfare of the child. It would be discouraging to keep a child safe from injury, but to allow deviant and retarded development to go unnoted and untreated.

When CPS workers are overburdened with caseloads, it may not be advisable for them to conduct assessments; there are many agencies and private practitioners who can perform these tasks.

Any CPS agency which sees more than a handful of children a year should seriously consider having a staff person hired expressly for the purpose of providing developmental screening. Administratively, it may be preferable to have a developmental screening

technician in the agency, rather than having that job be shared by all of the CPS workers. Possibly, a nurse from the local health department could be assigned to the CPS agency. The decision as to which route to go will vary with local politics and finances. It is within the scope of a child protective service worker to be capable of screening for developmental status. It can be a very gratifying part of child protective work. It is the responsibility of the agency to make some screening assessment of the children under their care. However, the exact mechanism for providing this service needs to be worked out locally.

Screening, by whatever method, is just that. Screening gives an indication that a child may have problems, but it does not give a developmental diagnosis. It does not give any idea as to why a child may be delayed. It does not give a format for a treatment or intervention strategy. It does, however, alert the worker that the child's development needs to be comprehensively evaluated. When screening has led the worker to believe that the child may very likely have a developmental problem it is time for referral or consultation.

GENERAL DEVELOPMENTAL EVALUATION

When the child's *overall* development is suspect, a general developmental evaluation is indicated. Resources for such an evaluation will vary in different communities, but often this evaluation can be done by:

- A developmentally trained pediatrician
- A clinical child psychologist trained in evaluation of infants and young children
- A developmental clinic, where several disciplines are represented
- The public school's special services personnel if the child is of school age
- Some child psychiatrists who are trained in developmental assessment
- A child neurologist who is trained in developmental assessment.

The consultation will usually take one of two courses. One approach, especially in the infant and young child, will be for the consultant to take a history and administer a developmental test, which measures

mental abilities, language, and motor skills, as well as other discrete areas such as perceptual-motor skills and memory. The other approach is to administer several different tests, such as tests of articulation, language, mental abilities, or perceptual-motor skills.

Either approach should address and answer the following three questions:

- What is the status of a child's development?
- If the child has delayed functioning, what are the likely reasons for the delay?
- What can be done to help accelerate the child's development?

When choosing a consultant to see a client, the CPS worker can use the following guidelines.

- Does the consultant have considerable experience in evaluating and working with children? Many psychologists, for instance, are not trained in the use of tests for infants and very young children. The techniques of testing and evaluation are quite different for younger children. It is essential for the consultant who is evaluating infants and young children to be aware of biologic forces which can impede development (for example, impaired vision or hearing, seizures, cerebral palsy or other motor dysfunction, alterations in the infant's state of arousal).
- Does the consultant supply the answers and data the CPS worker needs? Every consultation should produce the following information.
  - -- What tests or methods were used to evaluate the child? The CPS worker should know what tests were given, or what techniques or mechanisms the consultant used to come to his/her conclusions.
  - -- How did the child perform and what were the results of the tests and evaluations? These should be presented in layman's terms.
  - -- Why did the child perform as he/she did? For example, there are any number of reasons why a child or adult might obtain an I.Q. score of 60 on a test. Retarded mental abilities are only *one* possible explanation. The child or

adult might obtain that score because, for example, he was ill, feverish, having seizures, being uncooperative, unduly anxious, or could not hear well. The consultant must be more than a technician who gives tests; he/she must be a competent clinician who makes clinical judgments as to *why* a child performs as he/she does.

-- What recommendations does the consultant have for helping the child? Part of the consultant's role is to suggest specific places where the child might obtain necessary help.

-- The consultant needs to be able to work *with* the CPS worker and for the CPS worker, not independently. The consultant should discuss findings and recommendations with the worker and they should come to some consensus as to what plans to make. For example, they should determine who will inform the parents of the results, what treatment plans will be instituted, and where the treatment will be procured. The CPS worker then has an obligation to consult with the parents as to these findings and the resultant treatment recommendations unless parental rights have been severed.

-- The consultant should also provide assistance to school staff and early childhood program staff in order to help them implement treatment plans for specific children in their programs.

EVALUATION OF SPECIFIC DEVELOPMENTAL DELAYS

It is not unusual to find that a child seems to be developing normally in terms of his/her mental abilities, motor skills, and social abilities, but speech and language are delayed or deviant. In this instance, it is quite appropriate to consult a speech and language pathologist. Again, the same criteria apply as listed above for choosing a competent consultant. The speech and language consultant will usually choose to administer several tests to the child, and they will vary depending on the age of the child and where the consultant was trained. The Appendix lists some of the more commonly used instruments for assessing speech and language.

When concern centers exclusively around the child's motor abilities, a referral to a physician who sees children or possibly a pediatric neurologist is in order. Again, it is appropriate to apply the same yardsticks for consultants here as with the speech pathologist or the developmental consultant. Most often, delays in motor abilities reflect an immature or damaged central nervous system. Hence, the referral to a medical doctor who can assess the neuro-motor status of the child is in order. The consulting physician may be able to adequately perform this function, or may choose to obtain help from a physical therapist, pediatric neurologist, or developmental pediatrician. In most instances, the child who is delayed in motor skills or who appears clumsy and uncoordinated can be adequately evaluated by a general pediatrician or the child's family physician.

TREATMENT MODALITIES

Exact treatment plans for any specific child cannot be outlined here. Treatment will vary according to the child's problems, the community resources, and the philosophy of the professionals who are helping to plan the treatment. However, there are some general guidelines for planning treatment for children with developmental problems.

Generalized Developmental Delays

When the developmental delay is generalized and pervasive in a child from birth to three years, there are three main approaches which might help to accelerate the child's development.

- A home-stimulation program may be offered by some local agency or school. This requires a parent or parent-surrogate who has the energy and investment to carry out such a program. The "professional" usually comes to the home once or twice a week and occasionally the parent and child go the agency. The parent is guided in appropriate developmental stimulation activities. Inexpensive and/or homemade toys are all that is needed, for the most part. Frequently a manual or course book is used by the parent.

- A therapeutic day care center or school for delayed infants may be available. This is usually more intense than a home-stimulation program. Such agencies usually have staff who are trained in early

stimulation and may also have physical therapy and language pathology consultants on an as-needed basis. While primary treatment is carried out in the center, the parent should reinforce this treatment with appropriate activities at home.

- If it is felt that the child's development is delayed due to an impoverished home, it may be possible to have a diagnostic trial period of six months to see whether the child's development will accelerate in a more optimal home setting. This may include foster home placement, or preferably, having the child stay in some "adequate" home several hours a day (with a baby-sitter, in day care for normal children, or in a daytime-only foster home) while the child remains with his biological parents at other times. With this assurance of an adequate alternate home placement several hours a week, and with changes in the biological home which might result from a treatment plan, the child's development may well accelerate without the help of specifically trained child developmentalists. However, this must be considered a diagnostic trial; that is, if the child's development does not show signs of acceleration in three to six months, then a more formal intervention strategy must be instituted.

Regardless of the approach used to treat the child's delays in development, it is essential to provide the parents with assistance in dealing with the changes the child experiences as a result of treatment.

For children from the age of three to six years, a similar choice of options is available.

- A special or therapeutic preschool. This is a school for preschool-aged children which specializes in the educational and general developmental stimulation of children with delays. Some of the children in such a school will be retarded, and others will be delayed secondary to other reasons such as psychosocial deprivation. Just as in therapeutic day care, the staff should be trained in approaches which encourage cognitive, social, language, and motor development.

- Again, a diagnostic trial in an "improved" environment may be helpful. This may take the form of the child being in a normal preschool several hours per day, if the child's behavior is not so deviant as to preclude enrollment in a normal school. If the child has to be in foster care, it might be advisable to wait three to six months and then reassess his developmental status to see if this change in home environment may be enough to accelerate development. As stated above, this approach should be considered diagnostic, and discontinued in favor of a more formally structured developmental setting if no improvement is noted within three to six months.

  Other innovative approaches should be considered when the child remains in his/her biological home, whereby the child is assured of a more optimal developmental environment several hours per week, until the biological home has changed enough to make it a nurturing environment.

Enrollment of the abused child in preschool or day care as part of the treatment for children in this age group has several advantages.

- It offers a respite to the parents and to the child, without completely interrupting their relationship. All parents need time away from their children, and the abusing or neglecting parent can benefit from this also.

- The therapeutic preschool/day care setting provides general developmental stimulation for the child. This may be especially important inasmuch as the amount and quality of stimulation in the abusive home is likely to be quite limited.

- Preschool or therapeutic day care provides a vehicle for remediation of specific developmental delays. In fact, as will be noted later, it is effective to use professional subspecialists as consultants to preschools/day care programs because remediation may be provided best in such a setting.

- The preschool or therapeutic day care program provides the child with an opportunity to learn more healthy socialization patterns than his/her own home has provided. This includes interaction with healthy adults, as well as opportunities for peer relationships.

- Finally, the alternate care facility is capable of helping the child deal with personality deviations. But it is important to emphasize here that a sensitive, psychologically-oriented staff can be a most effective psychotherapeutic team in helping a child understand and modify his feelings and behaviors.

When the child is six years or older, some alternative approaches may be beneficial. The public school system should provide the special help needed for children who have delays in mental, language, learning, or motor development. This may include special class placement for children with developmental problems. Other options available in most school systems include: classes for learning disabled children; perceptual-communicative disorder treatment programs; classes for mentally retarded children; resource rooms for a variety of developmental problems; specialized help from special education teachers or language specialists; help with special problems such as reading disorders; or after school day care programs.

Public Law 94-142 requires all public schools to provide education for all children regardless of handicap. Many schools are still in the process of developing programs for children with special needs. In communities where schools are still not able to provide specialized services, private resources may have to be discovered to supply the treatment required for the special developmental needs of the child.

Specific Therapies

Children of any age may need specific intensive work with a subspecialist. This will be required when the developmental problem is quite delimited to a specific area, such as speech or language, motor skills, or perceptual development; or when the deficit or delay is so significant or so complex that a general "developmentalist" (such as a teacher or day care mother) cannot offer the necessary help. Such specialized treatment may be offered in at least two schema:

- The child may be taken to a physical therapist, occupational therapist, or language specialist for individual therapy. This is usually required at least once per week. It also frequently requires that the parent or parent-surrogate support the therapy through a directed program of home therapy.

- Preferably, the specialist can accomplish the same ends through consulting with a developmental generalist (such as a teacher, therapeutic foster-mother, or preschool staff member). In such a paradigm, the specialist will see the child periodically (perhaps once every one to three months) and instruct the generalist in what to do to enhance the development of the child in the area in which the child needs special help. The advantages of this approach are multiple, if it can be accomplished. The cost is less; the child does not have to be so overtly identified as "different" by going to therapy so often; and the specialized help can be offered in the context of a more general developmental program.

When specialized therapy is indicated, the same criteria should be considered as noted above under developmental consultation. The professional should be able to demonstrate experience and expertise in working with children of the same age as the worker's client. The professional must be able and willing to communicate openly with the CPS worker as to his/her treatment plans and the ongoing progress of the therapy. A physical therapist whose primary past experience is in working with adults with strokes or trauma is not a candidate to be a therapist for a young child with motor incoordination. It is the CPS worker's responsibility to choose a professional whose training, experience, and expertise are appropriate to the client's needs.

If the CPS agency is not aware of treatment resources, there are a number of ways to discover what is available in the community. The state or county health department should have a list of available resources for developmentally disabled children. Most states have a developmental disabilities office or council which has such referral information. In most states, there is a university-based child development center that can help with referral decisions. Specific organizations which have knowledge of resources include: Association for Retarded Children, Association for Children with Learning Disorders, State Speech and Language Association, State Physical Therapy Association, and State and County Medical Societies.

In summary, the Child Protection Agency is responsible for the safety, health, and welfare of the abused or neglected child. This responsibility must include the routine screening of each child for developmental status. Referral for consultation or therapy may be required for a majority of maltreated children. It should be a gratifying experience for CPS workers to identify and plan treatment for abused children so that they will not only be safe from future harm, but so that their growth and development can be enhanced.

VI

TREATMENT OF PSYCHOLOGICAL PROBLEMS

The stress of deprivation, neglect, and battering from parents requires psychological and physical adaptation. The younger the child, the smaller repertoire of adaptive behaviors he/she has. What are the options to the child: withdrawal, fearfulness, obeisance, fighting back? Children not only must adapt to the abuse, to the uncertainty of when they may be physically attacked, but also must adapt to the background of inappropriate parenting to which they are exposed. There may be any number of dynamics to which children must adapt. They may be in a family where there are unrealistic expectations of them; a family which rejects them or which is impatient with their attempts to grow up. Their family may be quite chaotic and socially unstable; marital conflict, including spouse abuse, may be present. They may be considered as bad children regardless of their behavior. As will be discussed subsequently, the child has also to adapt to the consequences of abuse being identified, for example, being separated from their parents, moved into strangers' homes (foster care), being hospitalized, suffering the pain and fright of their injuries, *and* treatment of those injuries.

It is not surprising, then, that there are a variety of psychological responses to abuse or neglect or that the majority of abused and neglected children have significant psychological problems. Variations in psychological adaptations of children will depend on their temperamental differences, the age of the child, the psychological variations in the parents, the parents' behavior and feelings toward the child, and on what happens to the child after abuse/neglect is diagnosed.

Some of the child's responses may be quite adaptive, in that they have great survival value, and yet be maladaptive in that they will impede learning, social ability, and may affect the child's happiness and maturation. For example, children may adapt by becoming quiet, inhibited, and withdrawn. This may decrease the physical pain they suffer, and yet will limit their opportunity to learn, to socialize, to mature and develop. Alternately, provocative behaviors can be understood as as attempt to get attention, to test the waters to see if they are safe, but this behavior is apt to alienate them from others. Similarly, the role reversal exhibited by pseudo-adult compliant behavior which has been described in many abused children may be an understandable survival approach. Yet

this behavior, in effect, robs children of their childhood. The child often seems to be repeating the growing up patterns which his/her parents went through; the frequent intergenerational transmission of abuse and neglect demonstrates that these children may grow up to be much like their parents: isolated, violent, needy, unloved and inadequate.

Often the emotional scars of abuse and neglect are much more far-reaching and severe than the physical scars. If intervention is impossible at this point, and if it is not possible to alter these children's psychological development, there is little hope of preventing future abuse and neglect, or of substantially decreasing the incidence of violence towards future children.

ASSESSMENT/SCREENING

Just as with developmental delays, CPS workers are the professionals who must bear the brunt of identifying those abused and neglected children who are in need of more extensive psychological evaluation. They have a pivotal role in deciding whether: the child is psychologically normal; the risk should be taken that changes in the biological home can happen quickly enough to undo the psychological damage that has been done; children should have more extensive evaluation; children have psychological adaptations which can be dealt with without the services of a child psychiatrist or psychologist.

CPS workers' first task is to make some assessment of the child's psychological state. They do not need to be psychiatric diagnosticians, but they do need to be able to make an estimate of whether a child seems all right, somewhat troubled or seriously maladjusted.

Psychological Milestones

There are psychological and social milestones, just as there are with language or motor skill achievements. With age and maturation children smile, recognize strangers, have stranger anxiety, enjoy interactive play, have separation anxiety, and engage in parallel play, then cooperative play. It is expected that children will have a temper which they express motorically from one to three years of age. It is not unusual to find a transitional object (a security blanket or its equivalent) being used by children under five, but it would be unusual in an eight-year old. Imaginary playmates can be expected with preschool children but not in adolescents.

Thus, one way to assess children is to determine if they have had, and are attaining, social and psychological behaviors which are appropriate to their age.

Developmental Stages

A similar approach could be to have a conceptual framework of the psychological tasks of differing developmental stages. For example, Erik Erickson's stages of development might be used as a framework.

Using this, the child by one year of age would be expected to have largely negotiated the sense of trust versus mistrust (which, like all of Erickson's stages, is never completely negotiated). If the child has no sense of trust in parents or loved ones, this is an alarming sign of disrupted development.

From one to three years of age, children should be developing autonomy. Some behaviors, such as the use of the word "no" and tantrums, demonstrate children's attempts to differentiate themselves from others and become psychologically autonomous (which is not the same as completely independent).

During the preschool years, children are practicing initiative and mastery. They are creative in their play, ask incessant questions, have fantasies, and engage in make-believe.

During the elementary school years, learning is paramount. For example, they learn to count, add, subtract, read, write, and they learn facts, such as state capitals and names of planets. They are interested in table-top games, as much in the rules of the game as in the outcome. They increase their sophistication and skill in motoric games, such as: hop-scotch, jacks, skateboards, skipping rope, kick-ball, and wheelies on a bicycle.

If CPS workers are acquainted with the normal developmental tasks of different ages, with the normal play activities of different ages, and with the reasons that children choose the games, then they will have a framework of normality against which to gauge the child. This is not an approach of matching specific tasks and skills against an age grid, but it is an approach which asks the CPS worker to appreciate the conceptual framework of successive psycho-developmental stages.

Symptoms

A third approach is the recognition of symptoms; that is, behaviors which seem abnormal, unusual, or those which are signs of intrapsychic difficulty. Many of these symptoms are behaviors which are provocative or intrusive; for example, aggression, hyperactivity, destructiveness, and misbehavior. Just as concerning are the symptoms which are less bothersome to adults: excessive shyness, fearfulness, inhibition, and fear of failure.

In addition to behaviors, unusual affect should be considered as a sign of emotional difficulty. Sadness, excessive seriousness, frustration, fear, or anxiety are frequently pervasive in the demeanor of abused or neglected children. Anger, apathy, and depression are also characteristic of these children.

Thus, CPS workers make some judgment about all the children in their caseloads. Whether consciously or not, they form some impression of each child as a person. It can be helpful and is important to organize those impressions so as to make more deliberate, conscious, enlightened judgments about the psychological status of each child. The following suggests ways to organize those impressions:

- How does this child's behavior fit the normal milestones of psycho-social development, such as smiling, stranger anxiety, separation anxiety, mastery of body functions, play with peers, masturbation, night terrors, or desire for privacy? How far awry does the child seem from the normal sequence of such behaviors?

- How does the child fit into a conceptual framework of psychological development? Is the adolescent dealing appropriately with his/her development of identity and autonomy? Is the latency aged child coping with academics and peer relations? Is the preschooler capable of autonomy and initiative?

- What are the prominent or significant affects of the child? Under what conditions is the child sad, happy, frustrated, afraid, and how does the child *deal with those feelings?* And how does his/her affective state interfere with learning, socialization, and maturation?

- Does the child have unusual symptoms or behaviors, for example, fire setting or smearing feces?

- What is the nature of the child's interactions with others, especially with peers? What is the play of the child like, and is it what would be expected at his/her chronological or developmental age?

- How does the child respond to stress? Be aware that underreaction is as significant as over-reaction to stress. For example, CPS workers should be alert to the child who shows no fear or anxiety to needle sticks or other stresses to which average children should react.

CONSULTATION

All of this screening is aimed at answering the following two questions:

- Does the child need psychological treatment?

- If so, what kind of psychological treatment would be optimal?

Depending upon the experience and self-confidence of the worker, and depending upon the picture the child presents, the CPS worker may be able to answer both of these questions. Alternatively,CPS workers may need, or want to have, consultation to arrive at the answers. The following are types of resources that could be used in this effort.

- CPS may have a mental health professional on staff, or at their disposal, who can provide consultation. This is an ideal approach since the need for consultation or referral will occur frequently.

- A child psychiatrist.

- A clinical child psychologist.

- A developmental pediatrician.

- An " expert" in children's behavior: for example, a teacher, counselor, or child-care worker.

- A mental health clinic, *if* they have a staff member who has experience with children of the same age as your client. Beware of the mental health clinic which primarily or exclusively deals with crisis mental health problems.

- If the child is in school, the school system may have one or more of these mental health professionals who can be used for help in evaluation.

TREATMENT MODALITIES

There are a variety of treatment modalities for mental health problems in children. The approaches discussed in this section are not exhaustive, but they have been found to be most helpful and are usually available in most communities.

CPS Workers

CPS workers can be the most important psychotherapeutic agents. Psychotherapy should not be confused with being psychotherapeutic. Friends, relatives, or colleagues are often the most important psychotherapeutic people in a person's life although they do not "do therapy"; these people provide support, present alternative solutions to problems, listen, and generally allow others to feel comfortable with them. CPS workers *may* provide formal therapy, but more often they can be psychotherapeutic with children, especially in a preventive fashion, in crisis situations, or in a role similar to the lay therapist.

When children enter the CPS process, they are frequently at a point of crisis. They may have recently been injured, or their neglect has become so serious that the family has been reported. They may also be separated from their parents, they may be the center of legal maneuvers, and they may be hospitalized. It is at this pivotal point that CPS workers can play a critical role. CPS workers should try to understand what children's fears mean to them. They can talk to the child, explain what is happening, and attempt to alleviate unrealistic fears and fantasies. More importantly, they can help children by being available, by listening to the children, and by eliciting their feelings about what is occurring and what is happening to them. Workers can reassure, clarify, and help point out that it is understandable to be afraid or sad. This approach has been used as a model for children who have just lost a parent, and can just as easily and profitably be used for the child who has just been hurt, deserted, or separated.

There are some general guidelines that CPS workers should be aware of in dealing with children. First, abused or neglected children are very likely to mistrust CPS workers. Workers should not personalize this mistrust, not should they try to convince the child to trust them. They can, however, gain the child's trust by being honest, by listening to the child, by being empathetic and showing concern.

CPS workers can play a role for the child which is similar to the parent aide; they can function as "child aides." They can be a healthy adult model to whom the child can relate. CPS workers can provide children with an adult friend whom they can talk to, rely on, and learn from. This role can be extremely gratifying to the CPS worker as well. The CPS worker can help the children to understand their placement in foster care, the legal machinations in which they are involved, and their parents' behavior. Abused and neglected children often have no one to rely on in this way. It is seldom that the guardian *ad litem* or the pediatrician will serve this function.

Alternate Care

Alternate care can be psychotherapeutic. As indicated in the section on developmental delay, alternate care may take many forms: day care, preschool, foster care, therapeutic foster care. This will alleviate some of the stress these children experience because they are able to spend time in a relatively normal, healthy environment. Further, most of these forms of alternate care should be staffed by people who, like CPS workers, can identify children's maladaptive behaviors and try to help children develop healthier behaviors.

Therapeutic Consultation

There are two types of therapeutic consultation which can be effective in treating abused or neglected children. Mental health professionals, such as child psychiatrists or child psychologists, can provide consultation to CPS based on information provided to them about the child; alternatively, they can see the child, conduct an assessment or evaluation, and then consult with service-providing agencies about their findings.

Having a mental health professional provide consultation to the professionals who are providing services to the child is extremely helpful. Abused and neglected children are often difficult to like, to understand, to enjoy, and to tolerate. Maladaptive behaviors are often quite ingrained and resistant to change. Day care workers, preschool teachers, foster mothers, or CPS workers can be most

helpful to the child *if* they receive ongoing consultation from a mental health therapist. The consultant can help these professionals determine what the behavior of the child means, how it might have developed, and most importantly, *what the professional can do to help.*

Everyone experiences the uncertainty of how to approach unusual behavior in maltreated children. For example, an abused child may seem quite regressive; a four year old may want to be held, fed, cuddled, rocked, and dressed. What should be done? Should the position be taken that the child has missed out on early parenting and needs to experience this more primitive infantile state? Or, by acceding to this regression, is the child's future development impeded? No one answer can be given; the answer can only be determined by understanding what is happening right now with the particular child. The mental health professional should be able to provide such understanding. Mental health professionals also give legitimacy to CPS workers who are uncomfortable with their instincts or intuition by professionally legitimizing their approach to a child.

Using mental health professionals as consultants rather than to provide direct therapy to the child has many advantages: it is economical; it may, in one hour's time, provide many hours of understanding and psychotherapeutic help to the child. It will provide information which can be generalized to other children. In addition, this form of therapy does not have the stigma of psychotherapy, so it can be advantageous when individual direct therapy is not really required.

This form of help for abused and neglected children is not often considered. It may be helpful for CPS workers to raise this as a possibility, seeking out an answer as to whether this might not be helpful and possible with children in their caseloads.

Multidisciplinary Case Consultation Teams

The use of multidisciplinary case consultation teams is an effective way to ensure consultation with mental health and other professionals. Abusive and neglectful families have multifaceted problems with can be best treated through multidisciplinary efforts. Multidisciplinary child abuse and neglect case consultation teams make optimal use of special skills and professional knowledge to benefit these families.

For more detailed information on case consultation teams, the reader should refer to Schmitt, *Child Protection Team Handbook.*[1]

Mental Health Therapy

Some children will require, or maximally benefit from, direct therapy from a mental health professional. This mental health therapy can take any number of forms: individual psychotherapy, group therapy, family therapy, or, for the very disturbed, residential therapy.

The child who cannot be helped through less intensive intervention should be considered for formal psychotherapy. A psychiatrist or psychologist could provide assistance to CPS workers in determining which children could benefit from this type of help. Mental health therapy is generally less available, and more expensive, but is probably indicated in only 10% to 20% of maltreated children.

RATIONALE FOR TREATING THE EMOTIONAL NEEDS OF MALTREATED CHILDREN

Few children can escape the devastating psychological wounds from being beaten, deprived, neglected, or rejected. The issue is not really whether the child is labelled "emotionally disturbed." The critical issue is to help these children deal with their past, their present circumstances, and their future in such a way that the child has a fair chance of growing up into a content, well-adjusted adult. There is a need not only to save these children from physical and developmental harm, but to intervene in such a way as to maximize their chances of having a happy, satisfying childhood and a healthy adult life.

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[1] S.C. Schmitt (Ed.), *The Child Protection Team Handbook: A Multidisciplinary Approach to Managing Child Abuse and Neglect.* (New York: Garland Press, 1978).

VII

CHANGING THE HOME ENVIRONMENT

Although this manual was developed to address the issue of treatment for abused and neglected children, it would be lacking if it did not address the issue of coordinating the treatment of abusive and neglectful parents with their childrens' treatment. Abusive and neglectful parents and their children should not be treated in isolation. Whenever possible, children and parents should receive treatment together or concurrently. This maximizes the potential for positive changes in the parent-child relationship, in parental attitudes, in parenting skills, and in the child's behavior.

Abusive and neglectful parents need to receive help for their own unhappiness and problems; but in addition, the parents need to have changes in their parenting abilities if the child is going to be able to remain in or return to his or her biologic family. Thus, treatment for the parents can be considered as an *indirect* form of intervention for the child if the goals of treatment are to provide a more healthy environment for the child. This is a critically important differential. Abusing parents may receive various sorts of help, help which is clearly beneficial to them; and yet their attitudes and behaviors towards their children may not change appreciably. The issue of timing has been addressed above. In reiteration, abusive and neglectful parents will probably only be in a position to change their behaviors and attitudes towards their children after they have begun to have some of their own needs met. This requires the professionals working with these parents to be capable of shifting their intervention to meet the goal of altering parenting behavior. This will be essential if the treatment for parents is to benefit the abused child.

Whatever the treatment goals for the parents, children, and family, it is optimal if the parents are involved in the treatment planning process. Whether or not the family is involved in the planning process, it is important to develop a service agreement with the parents (and children if applicable) which specifies the treatment goals and the estimated length of time to meet these goals.

MEASUREMENTS OF PARENTAL ADEQUACY

The question frequently arises as to when the adult is prepared to provide adequate parenting to the child. Not only must the critical issue of safety from physical harm be addressed, but the CPS worker must also consider whether the family can provide an environment which will allow normal growth and development.

Too often, agencies use inappropriate measures of improvement in abusive/neglecting parents. Most often, this determination is based upon compliance with CPS. For example, is the parent keeping appointments, following suggestions, or obtaining employment?

These measures of compliance may or may *not* reflect changes in parenting patterns. Agencies should develop clearly conceptualized, objective,and measurable criteria for changes in the parents' behavior which will predict adequate parenting. In addition, these criteria should directly relate to changes in parent-child interaction. The following are some criteria[1] which could be altered or expanded upon in order to assess whether the environment is safe and adequate.

Changes in the Parent

Each professional will have his/her own guidelines for determining improvement in their clients; these guidelines should be specific to the individual client. The parents' personality or character profile must be used to develop specific treatment goals. The following are suggested guidelines which could be used for this purpose.

- The parent should be capable of dealing with anger appropriately, rather than just through physical means, such as violence.
- There should be a decrease in isolation exhibited by the parent's ability and interest in enjoying friends, family, or other people.
- The parent needs to develop an ability to use people or activities as lifelines of support. It is essential for the abusing/neglecting parent to have the capability of turning to others for help when he/she is either overwhelmed or in need of help or support. These lifelines may be the CPS worker, friends, neighbors, a parent aide, or some other professional.
- The parent's self-concept should have improved.
- The parent should demonstrate an increasing ability to enjoy life.

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[1]Beezley. In: H.P. Martin (Ed.) (*The Abused Child: A Multidisciplinary Approach to Development Issues and Treatment.)* Chapter XX, "Therapy for Abusive Parents: Its Effects on the Child." Cambridge: Ballinger, 1976.

- The parent should develop more realistic expectations of him/herself, and of others.

- Self-destructive patterns of interpersonal relationships must be broken. For example, a mother must break the pattern of repeated involvement with violent men.

- The parent should increase his/her repertoire of coping mechanisms. All adults experience stress and there needs to be some assurance that these parents can deal effectively with stress rather than venting their frustrations on their child.

Changes in Parent-Child Interaction

Assessment of the parent-child interaction in a particular family will suggest family-specific treatment goals. The following are suggested guidelines which can be used for determining whether the parent-child interaction is adequate enough to promote the child's growth and development.

- The parent's expectations of the child are age-appropriate and reasonable.

- The parent can enjoy the child, and can take pleasure in the child's age-appropriate behaviors.

- The parent is able to tolerate and understand the child's negative behavior. This parental ability is necessary since all children will be provocative, will misbehave, and will test their parents.

- The parent must shift from viewing the child primarily as a need-satisfying object to seeing the child as an individual. This involves respect and empathy for the individuality of the child rather than viewing the child as an extension of one's self.

- The parent must be able to allow the child to have meaningful and gratifying relationships outside of the nuclear family.

- The parent should be able to express affection towards the child, verbally and physically. This may take the form of age-appropriate praise, reinforcement, or physical cuddling.

TREATMENT OF THE PARENT-CHILD INTERACTION

While individual treatment for a parent, or for the couple, may accomplish changes in attitudes and behaviors, it is suggested that direct intervention is needed in the parent-child interaction. The following are some suggestions for intervention in the parent-child interaction.

Parent-Child Visits

When abused children are in foster care or some alternate living arrangement, it is common practice for the biological parents to visit the child at specific intervals. These visits, which are usually held in the CPS or foster care worker's office, are primarily used for monitoring or assessing the parent-child interaction. This puts tremendous stress on the parents who, at each visit, are in the position of "proving" their attachment to the child. These visits can be used therapeutically. Why not take this opportunity to try to mold, shape, or change parenting behaviors? It is not only important to monitor the parent's behavior, but to help the parent understand the child's behavior and learn appropriate child rearing techniques. These parent-child visits offer a situation in which workers can help the parents change their beliefs, attitudes, and behaviors. If parent-child visits are to be used as a therapeutic experience, it is essential to reduce the stress of the situation. This could be accomplished by arranging the visits in more natural surroundings, such as in the foster home, or in the biological home. CPS workers should schedule the visits in view of what would be most helpful in changing parenting behaviors.

Home Visits

If the child is living in the biological home, home visits by the worker can be utilized to teach child development and child management. The ultimate goal of these home visits is to facilitate change in the parents' attitudes and behavior towards their children. Workers should remember that modeling appropriate interpersonal and parental behaviors is a very effective method to achieve this end, and should be conscious of the behaviors they model during home visits.

Parent Education

Formal parent education might be considered in a treatment plan for the parents. Most communities have a great variety of parenting classes available. Some agencies have found Parent Effectiveness Training, or some similar approach, to be quite helpful with many

of their abusive or neglectful parents. Parent education and parent training are most effective in combination, and in order for these programs to succeed with abusive and neglectful parents they must also include a large element of nurturing for the parents. At any rate, specific programs which address the issue of changes in parents' attitudes, knowledge,and behavior should be considered as a treatment modality for most abusive and neglectful parents. Successful programs have used a variety of approaches; the exact theoretical framework is not at issue here, for no one has documented the necessary elements in such programs for abusing parents. The important consideration in these programs is that parenting improve for the sake of the child. The bibliography at the end of this manual includes references from Dreikurs, Gordon, and Justice, which may be of help to CPS workers in parent education efforts.

Parents' Groups

The success of parents' groups, as a component of children's programs, has varied somewhat. It has been demonstrated that enriched preschool programs, such as Head Start, can greatly increase their value to the child if there is active involvement of the parents. At least two therapeutic preschool programs for abused children have found that an active program for the parents of the preschool children has been helpful in making some changes in parenting patterns. CPS agencies might well learn from such experience and consider parents' groups in conjunction with specific child-treatment programs.

Family Therapy

Family therapy has not been used extensively with abusive or neglectful families, so there is little written data describing its effectiveness as a treatment modality. However, it could offer an opportunity to address more than abusive or neglectful behavior; with family therapy it is possible to address the whole family's interaction patterns. There is evidence that the entire pattern of family interactions is deviant in maltreating families, and further, that it is possible to address and change those patterns without focusing exclusively on the abusive or neglectful behavior.

In relation to this, videotaping of parent-child interactions can be utilized as a teaching mechanism. The parent and therapist can observe the videotape and use this experience to analyze the child's behavior as well as the parent's responses and feelings.

IMPROVING THE HOME ENVIRONMENT

Treatment of the environment with a focus on changing parenting behavior is often overlooked or ignored. One reason for this over-

sight is related to the timing or staging required with this type of focus. The following material discusses therapy for the abusive or neglectful adult in three phases.

Phase one must often precede the latter two phases. In this phase, there is an emphasis on nurturing, on giving to the abusive parent. The abusive adult is a very needy person, who frequently must be "parented" before any changes may be made in his/her behavior. Parents may continue to require nurturing for months or years. The parent aide concept as well as parents' groups such as Parents Anonymous place a high priority on providing such support.

The second phase of treatment begins when the abusive adults are ready to make some changes in their own lives. In this phase, parents will have an interest in understanding themselves, and in understanding and changing self-destructive patterns. This is the first time where parents want to make changes in themselves rather than in outside factors.

It is probably only after these two phases of treatment have been instituted that the third phase can begin. This third phase includes direct intervention in and help with the parent-child relationship. When this phase of treatment is begun prematurely, the therapist might become quite disappointed and disillusioned at the lack of progress. Even during this phase, there continues to be a need for nurturance and direct assistance for the parent.

In summary, the environment of the child needs attention. If the child is to continue to live with parents who have been abusive or neglectful, the environment must be made safe. Further, it must be an environment which will allow if not facilitate the normal development of the child. Thus, treatment plans need to include a program for intervening in the environment, in the parent-child interaction which resulted in abuse or neglect.

VIII

HARMFUL EFFECTS OF TREATMENT

In any serious consideration of treatment for abused children, it is necessary to consider the harmful effects of such treatment. All therapeutic procedures carry some risk of harm. This is a theoretical and a practical position which is too little appreciated. Certainly, from the field of medicine, such a position seems unassailable. Any surgical procedure, no matter how minor, carries a certain risk of mortality and a higher attendant morbidity. No matter how common and innocuous, all medications similarly carry a certain risk. Research has revealed an ever-increasing number of substances, including x-rays which can endanger a fetus if it is exposed during a woman's pregnancy. Even oxygen, as essential as it is, is toxic to premature babies, resulting in blindness when given in high concentration.

So it should be natural enough to consider what harm might be done to an abused or neglected child through therapeutic procedures; further, it is necessary to consider the degree of the risk and the seriousness of the harm when considering any therapy. More important, consideration must be given to minimizing those harmful side effects of intervention which must be accepted because of their essential nature. Methods must be found to ensure that the pain and trauma of providing help is less serious than the conditions for which it was prescribed.

The case of Sarah provides an example of this problem. Sarah was physically abused when she was eight months of age. She had probably been mistreated before that time. At eight months she was taken to a hospital where a fractured arm, three fractured ribs and numerous bruises and cigarette burns were identified. She was hospitalized for 10 days and then put in a foster home. After considerable work with her 20-year-old mother, she was replaced in her biologic home at 18 months (after two foster home changes). Within five months, abuse was diagnosed again. After a short hospital stay, she was placed in a fourth foster home. Between 23 months to 55 months of age she had three subsequent foster home changes. The biologic mother was given a number of services. Relinquishment was considered a number of times, but the mother was not willing to voluntarily give up her daughter, and the mother's willingness to use prescribed intervention seemed to make a case for termination of her parental rights untenable. Finally, at 55 months of age, Sarah's mother relinquished parental rights and adoption plans were under way. An evaluation of Sarah at this time revealed a child of

probable normal intelligence who was functioning about one year behind her chronological age. She was an attractive little girl who displayed indiscriminately quick affectionate behavior towards one and all, friends and strangers. Psychiatric evaluation revealed a seriously disturbed child, prepsychotic, who had minimal capacity for object relations, and who had demonstrated repeated acting out behaviors in foster care which resulted in the repeated failures of each foster home placement.

This story of Sarah is not novel or surprising to any CPS worker. The abuse and neglect she was subjected to in infancy were harmful. But how much more harmful were her experiences once she entered the helping system? In less than five years she had experienced eight changes in homes. She had had to adapt to nine mother figures; she had never lived more than 19 months with any single one of them. When Sarah was in foster care, none of the surrogate mothers could, or would, become a psychological mother to her. Their role was a temporary one. They could not commit themselves to this little child. And so she was safe from physical assault, but she never really had the investment and commitment which is normal with biologic parents. Now at 55 months of age, she is clearly not a good candidate for adoption. There is no reason to believe that an adoptive placement would be any more successful than her seven previous foster placements.

Blame for a situation like this cannot be placed on any particular agency or policy. But there certainly must be an acknowledgment that this little girl has suffered considerably more harm from intervention than she did from her fractured ribs and arm. Her bruises have disappeared and her cigarette burns have scarred over and are barely noticeable. However, the psychic consequences of multiple parenting, adaptation to the loss of eight mothers in less than five years, and the uncertainty and transiency which has never allowed separation and individuation to develop have not disappeared. Object relationships are deviant, not surprisingly, as Sarah has never had a constant love object to whom to attach and bond. While she may represent a therapeutic success in that she has been spared significant long-lasting physical damage from assault, she just as certainly represents a therapeutic failure in that treatment plans have not allowed her the opportunity for normal psychological and cognitive growth and development.

METHODS FOR AVOIDING HARMFUL TREATMENT EFFECTS

The following guidelines present methods for avoiding harm to maltreated children through some of the more common treatment strategies employed with them.

Hospitalization

Hospitals are not good environments for children. Obviously, hospital care is often indicated or essential for a child. However, given the overwhelming evidence that hospitalization has the potential to warp children's personalities, ways must be found to minimize that risk.

First, it is not advisable to hospitalize a child if there are no medical indications. The CPS worker should consider foster care rather than hospitalization for the failure-to-thrive child in order to determine whether the child will gain weight in a different environment. When the medical procedures have been completed for an abused or neglected child, the child should not be left in the hospital until a treatment plan can be arranged. Instead, the child should be placed in a foster home until those plans are made and permanent arrangements for child care can be determined.

When the child *is* in the hospital, it is important to minimize the effects of inconsistent and erratic caregivers. The charge nurse on the ward may be able to assign a particular nurse or aide to the child on each shift for such things as feeding and bathing. The child should not be moved from room to room unless there are medical indications. If the hospital has a foster-grandparent program, this could provide the child with a constant companion for at least a few hours each day. If the hospital does not have such a program, a volunteer can be found to spend some regular time with the child each day during hospitalization. In addition, medical staff should talk to the child and explain what the diagnostic or treatment procedures are before they are carried out. Hospitalization is a good time to assess the developmental and psychological status of the child as described in sections above. Cognitive stimulation and psychological treatment can start when the child is in the hospital.

The child should be prepared for discharge from the hospital, especially when he/she has been there for more than two to three days. Children get attached to, or accustomed to, the hospital setting just as they do to a home setting. The child should not be precipitously discharged, but should be informed at least 24 hours in advance that he/she is going to be leaving the hospital. Children should be told where they are going and given a chance to "say goodbye," literally and figuratively, to the staff and the other patients. Separation from familiar people and places usually requires some adjustment, but it may be even more difficult for these children. Saying goodbye is especially pertinent to hospitalization because of the regression which the hospital setting encourages. The child must be prepared to reenter a more natural environment.

Separation From Parents

Separating children from their parents is always traumatic, even for children who have been abused and neglected by those parents. In most instances, the child still views the parents as important love objects. It is important to remember that even though the parents have been inadequate, separation still represents a significant loss to the child. When there is reason to believe that there is a possibility of returning the child to the home, it is essential to maintain the bond and attachment the child has to the parent. Visiting and other forms of contact between the parent and child should be as frequent as possible. When the parent wants no contact with the child, or when the agency is recommending permanent relinquishment, the child should be treated in the same way as a child who has lost a parent from some other cause, such as death or divorce. There is a whole series of literature on parent loss, including information on programs to help children adapt to this important loss. Loss of a neglecting, abusive, or inadequate parent may be just as traumatic to the child.

Separation and Loss

As has been noted previously, leaving people and places is a stress on children or adults, but it is especially difficult at certain times in the individual's life. Because of this difficulty, it is always preferable to avoid separations and losses whenever possible. This is one of the reasons why part-time alternate care has been emphasized so strongly in previous sections.

Much of the data regarding the effects of separation and loss are found in research on maternal deprivation. Spitz, Bowlby, Provence, and Ainsworth are a few of the pioneers who have written in this field. Immediate effects of separation and loss include developmental retardation, depression and apathy. The long range effects are not as well documented, but many experts believe that children who have suffered separation and loss of parents, *without intervention*, are highly likely to grow up to be adults who lack affection and who are only minimally capable of intimacy and closeness with other adults. It is also possible that borderline personality and antisocial acting out behaviors are related to parent loss when the loss is not dealt with by the child and surrounding adults in a healthy manner.

If separation is inevitable, it is crucial to help the child by anticipating the loss. The child will go through some grieving as part of the natural, normal process of termination. This termination process will vary in intensity and importance, but it is always present in leaving or losing biologic parents, foster parents, the hospital, CPS workers, or treatment settings. The CPS worker can modify the stress of separation and loss by helping the child to negotiate an appropriate termination.

Many of the components of termination are identical or similar to those phases everyone goes through when faced with the death of a loved one. The child may deny or repress the importance of the person or place he/she has left. Sadness, anger, guilt, and ambivalence are always present to some degree. The worker can help the child acknowledge and identify these various, and often conflicting, feelings. The child's inaccurate fantasies need to be elicited and discussed. It is very common for maltreated children to feel they are being removed from a home because they are bad; they often believe that injuries and placements are justifiable punishments for their bad behavior and thoughts. It will be helpful if the CPS worker can explain the real reasons for any changes to children and help them give up unrealistic fantasies and assumptions. The child will need help in admitting and expressing feelings of sadness or anger. The CPS worker can help the child say goodbye and accept his/her feelings about the loss or separation.

There is no good time for separation or loss, in the sense that it is always a cause of stress. Yet, there are times when separation and loss are *more* traumatic than other times. One of these stages usually occurs in the middle of the first year of life. Up to this point, the newborn does not appreciate differences in adults. There is no acknowledgment of strangers; any adult who meets the baby's needs will do equally well. As the middle of the first year approaches, however, the baby begins to show signs that he/she is appreciating differences in people, and this often is followed by stranger anxiety. At this point, the mother and father are *special* and cannot be easily replaced. The infant is showing clear, overt signs of attachment and bonding to certain people only. This phase in Mahler's[1] conceptualization of separation-individuation is embedded in Ericson's stage of development of trust. At this point, when the infant is developing a special trusting attachment to the parents, separation and loss are especially traumatic. They disrupt the establishment of the special love relationship which is just developing between the parents and the child.

Another especially sensitive period generally occurs in the middle of the second year of life, in what Mahler refers to as the "rapprochement" phase of separation-individuation.[2] At this stage, the child is toddling; upright, free locomotion and the beginning of representational intelligence have emerged. This change in thinking will allow speech and language, as well as symbolic play, to develop. The child has been developing separation and individuation, but now is moving more rapidly towards becoming a separate entity. With this sudden forward spurt comes an

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[1]M.S. Mahler, *et al. The Psychological Birth of the Human Infant: Symbiosis and Individuation.* New York: Basic Books, 1975.

[2]Ibid.

increased need and dependency on the loved person. The toddler needs the parent for purposes of touching base and gaining reassurance. It is now safe for the child to put greater distances (physically and psychologically) between himself/herself and the parents *if* the child knows the parents are still there and available. One indicator of this phase is the increased separation anxiety of the toddler. It is during this rapprochement phase that children become more and more aware of their separateness and of the dangers involved in being on their own. They realize that as they deal with the world on their own, it is not all that easy. The child desperately needs a parent to whom he/she can return for sustenance and reassurance. If the mothering figure is not there, not available, or not able to allow herself to be used as a sign of safety, the rapprochement crises will not be successfully conquered. This, then, is another stage where separation or loss of the parent figure will be especially stressful and traumatic.

The CPS worker does very often have choices in placement. There are times when a child could be moved from one home to another or when a change could be made later instead. When making this decision, the CPS worker should take the developmental stage of the child into account. This should also be *one* of the factors in the decision about retaining the child in the family. If, for instance, a child has been in a foster home for several months and is just entering either of the two stages of development described above, returning to the home should be postponed for a few weeks or months. A permanent placement which could be arranged before six to eight months of age would be ideal because it would avoid disrupting the beginning attachment of the infant to the present caretaker. Changes in home placement should be arranged before or after the rapprochement phase. Of course, the specific psychological milieu of the child should be considered -- *at any age* -- when options are available for placement.

Separation and loss are always stressful, but CPS workers can make some assessment as to whether the stress is apt to be *especially* difficult at a particular time and stage in a particular child. Thus, judicious planning may minimize the psychological trauma to the child.

Changing Placements

The frequent foster home changes which are so common with maltreated children represent a major problem. While there are many reasons for these changes, it is certain that *some* of them result from the behaviors of maltreated children which lead to repetitious failures in foster placement. If, and when, psychiatric consultation is regularly and routinely available (as suggested in a previous section), the foster parent can obtain professional help to understand the child's provocative or deviant behavior and to help discover strategies for

dealing with these behaviors. This may significantly decrease the frequency of foster placement failures, in turn decreasing the attendant home changes and parent losses the child must otherwise endure. The vignette describing Sara accentuates the trauma of repeated changes in home placement and emphasizes the need for *prevention* of such unnecessary foster home failures.

Protracted Foster Care

The individual CPS worker may feel relatively impotent to intervene in the protracted "temporary" placement of maltreated children. Agency policies, laws, and attitudes of judges may have to change before the harmful effects of indefinite foster care can be appreciated and this practice terminated. The individual worker can, however, advocate for the child by repeatedly raising the question of when parental rights should be terminated so that permanent placement can be considered for children who are in foster care for six months or more. Many abused and neglected children remain in foster care for years and years with no visits from their natural parents. This pattern must be avoided. The CPS worker can elicit the concern and conscience of the agency or court by initiating discussion about the effects of interminable foster care, the chances of return to the biologic home, and the time limits which should be placed on foster care where there are no permanent plans for the abused or neglected child.

The CPS Worker as Psychotherapeutic Agent

Through parent loss, court hearings, hospitalization, foster placement, and other stresses which occur *after* maltreatment has been identified, the CPS worker can, and perhaps must, take on the role of psychotherapeutic agent with the child. There has been some discussion of this in a previous section. Children of all ages need someone who is there, who can help by listening, explaining, nurturing, and providing a healthy adult model.

It may be difficult for CPS workers to realize the importance they have to abused and neglected children. They are powerful figures, often much more powerful in the child's eye than the biologic parents. They provide protection. Like school teachers, CPS workers are imbued with many unrealistic qualities and traits by the child. They may be figurative parent surrogates, fairy godparents, or idealized aunts and uncles. For these reasons, it is essential that transferring children from one worker to another be kept at a minimum. When it is unavoidable, CPS workers *must* help the child go through a termination process. Children often do not allow their feelings and fantasies about a loss to be visible. CPS workers must not underestimate their importance and be taken in by a child's seeming indifference. To do so will induce further stress in the child.

IX

SUMMARY

This manual has stressed the high rate of neuro-psycho-developmental morbidity in the survivors of child abuse and neglect. The public must be made aware of the effects of being raised in abusive and neglectful homes. It is easy to garner concern and support of a child's physical injuries or malnourished state. The child's psychological stress, developmental delays, and medical needs are less dramatic and less obvious. Yet, in the survivor of child maltreatment, it is these types of consequences which will most severely limit the developing child's subsequent growth and healthy adaptation.

If the neuro-psycho-developmental wounds of maltreated children are to be treated, there is an initial need for recognition. For most victims of child abuse and neglect, recognition will occur only through the efforts of CPS workers. Thus, it has been suggested that CPS workers monitor the medical needs of children and screen the children in their caseloads for developmental status and psychiatric problems.

The second pressing need of abused and neglected children is to have CPS workers function as advocates for them, assuring that they receive all necessary evaluations and treatment services. This is part of the advocacy role which must become the responsibility of CPS workers.

Finally, this manual has also emphasized the intervention-induced traumas which many maltreated children undergo. Some of the interventions which result in stress for the child may be unavoidable; indeed they may be quite essential to the child's welfare as in some instances of hospitalization, separation from parents, or foster placement. However, it is imperative that the stressful effects of such interventions be minimized through appropriate preventive actions by CPS workers.

There are other interventions by the helping system which may be unnecessary; for example, hospitalization without medical indications, protracted foster care, or inadvertent loosening of parent-child bonds through restrictive visiting policies. It is particularly important in these cases that CPS workers, functioning as the child's advocate, take a firm stand in trying to avoid and/or discontinue such psychologically traumatic plans.

This manual has broadened and deepened the concept of treatment and intervention for maltreated children. Concern about the physical injuries of children, while a first priority, is not in itself an adequate goal for child protective services. The identification and treatment of medical problems, developmental delays, and psychological trauma are relatively new but crucial aspects of CPS intervention. In such a paradigm, there is a chance that maltreated children can grow and develop from healthy and happy children into well adjusted, healthy adults.

APPENDIX

TESTS USED TO ASSESS DEVELOPMENT, SPEECH AND LANGUAGE

TESTS FREQUENTLY USED TO ASSESS DEVELOPMENT OF CHILDREN

Bayley Scales of Infant Development (1969). This is a developmental test for children from birth to 30 months of age. It has a motor scale and a mental scale. An infant behavior record is less often used. Bayley Scales is very well standardized and stands as a most respectable infant test.

Gesell, or Revised Gesell Developmental Schedules (1947 on). This is a test for children from 4 weeks to 6 years of age. It is divided into motor, adaptive, language and personal-social scales. While there is legitimate criticism of the standardization, it is an excellent clinical tool in the hands of an experienced developmentalist.

Griffiths Scale of Mental Development (1954, 1970). Similar to the Gesell, this is a "British" version, standardized on English children. The five scales are locomotion, personal-social, hearing and speech, eye and hand, and performance. It was originally a test for children from birth to 2 years, but has recently been extended for up to 8 years of age.

Cattell's Infant Intelligence Scale (1940). Also similar to the Gesell, this was an attempt to extend downward in age the Stanford-Binet. It covers children from 2 to 30 months of age. It gives a mental age and I.Q. score.

Merrill-Palmer Scale of Mental Tests (1931). Testing children from 1.5 to 6 years of age, this test is highly loaded with performance items and has very few language tests. It is inherently interesting to most children.

Stanford-Binet Scales (1972). This is appropriate from age two through adulthood. It is heavily loaded with language items after age six, and has many perceptual-motor tasks in the preschool years. It gives an overall I.Q. and mental age.

McCarthy Scales of Children's Abilities (1972). This is a test for children from 2.5 to 8.5 years of age. It has five different scales: verbal, perceptual, quantitative (knowledge of numbers), memory, and motor. It also gives a General Cognitive Scale (GCS) which is a combination of performance on the first three of the five scales listed above.

Wechsler Preschool Primary Scale of Intelligence (1963) (WPPSI). This is a downward extension of the WISC, covering children from 4 to 6.5 years of age. Like the WISC, it has five subtests which combine to give a performance I.Q., and five subtests which combine to give a verbal I.Q. A full scale I.Q. is also derived. The many subtests are valuable, especially in handicapped children.

Columbia Mental Maturity Scale (1959). This is a test for children from 3.5 to 13 years of age. It is often used for difficult-to-test children, inasmuch as it requires very little verbal direction and response. It tests reasoning. The child is presented with cards with pictures, from which he must choose the "one that doesn't belong."

Leiter International Performance Scale (1952). This is a test frequently used with deaf or language-impaired children inasmuch as it requires no verbal directions and no verbal responses. It tests children from 2 years of age through adulthood. Conceptual formation is measured, as in the Columbia Mental Maturity Scale.

Vineland Scale of Social Maturity (1965). This is a test frequently used for severely and profoundly retarded children. It does not measure mental abilities, but self-help skills and social maturity. It includes a list of questions to be asked of the parent or caretaker of the child. It does cover birth through adulthood. It may be the only way to get some objective measure of development in the severely retarded child who cannot be tested directly.

Wechsler Intelligence Scale for Children-Revised (WISC-R) (1971). Like the WPPSI described previously, this has five verbal and five performance subtests. It is applicable to children from 6 to 17 years of age. It is felt by many to be the most valuable tool to assess intelligence in this age group.

There are a variety of tests, called "achievement tests," which are commonly used with school-age children. The most widely known achievement tests are the WRAT (Wide Range Achievement Test) and the PIAT (Peabody Individual Achievement Test). Achievement tests are designed to measure how well a child has learned academic subjects. Results are usually reported in grade levels, that is, a score of 3.6 in reading means the child is reading at the level of the sixth month of the third grade. Achievement tests can be an indicator of academic progress which is often independent of intelligence.

COMMON TESTS OF SPEECH AND LANGUAGE*

ARTICULATION

Denver Articulation Screening Exam (DASE): This is a screening test, quick to administer, which samples some of the sounds of English. Responses are scored as correct or incorrect, and a total count of correct pronunciations yields a percentile ranking for ages 2.5 to 6 years. Coupled with assessment of spontaneous speech, this yields a score of normal or abnormal. It is useful to the speech pathologist and can be administered by others who receive some special training. (Materials are available from the same source as the DDST.) Results do not detail the type of articulation errors, but do indicate whether a child should be referred for further evaluation.

Goldman-Fristoe Test of Articulation: The test stimulae, bright, large pictures, are appealing to children. Results can be utilized to give a percentile ranking for 6 to 16 year olds; to describe the articulation error pattern; and to help predict the ease with which errors can be corrected. It is useful for preschoolers even though percentile scores are not available for that age group.

Fisher-Logemann Test of Articulation Competence: This is also a useful test for preschoolers. It includes a screening test; a complete test; and a method of analyzing the articulation errors to assist a therapist in designing an appropriate treatment program. Pictures are included for the younger child and there is a sentence portion for children old enough to read.

VOCABULARY

Peabody Picture Vocabulary Test: A well-known test of receptive vocabulary, this applies to children from 2.5 years to adulthood. Single words are spoken by the examiner, and the child, looking at a page with four pictures, points to the correct response. The results can be compared to age norms, put into percentiles, or converted to an intelligence quotient. It must be emphasized that this should *not* be considered a measure of general intelligence or general cognitive development.

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*The assistance of Ms. Janis Volkening in developing this exhibit is greatly appreciated.

LANGUAGE DEVELOPMENT

Tests of language may be administered using parental reports or by direct testing of the child. There are advantages and liabilities with either approach.

Parental Reports

Verbal Language Development Scale (Mecham): This test includes questions regarding skills in speaking, understanding, reading and writing from birth to 15 years of age, being most sensitive in the earlier years. A language age is determined with the results. Guidelines for interpretation of those results are not given and, therefore, the test should be considered to have screening value only.

Receptive Expressive Emergent Language Scale (REEL): The REEL assesses expressive and receptive language in children from birth to age three. These ages can be translated into language quotients for comparison to other tests. The separate measures of expressive and receptive language are an advantage of this test. Due to lack of clear guidelines for administration and interpretation, it should only be used by persons who are knowledgeable in testing and in language disorders.

Observation of Child

Sequenced Inventory of Communication Development (SICD): The SICD combines questions for parents along with testing of the child age 4 months to 4 years. It has separate subtests for expressive and receptive language and yields an age score in both areas. It is designed to help determine specific areas of strength and weakness. For example, it provides information concerning different types of behaviors of the child, such as imitation, initiating versus responsive behaviors, understanding, and discriminating auditory input.

Illinois Test of Psycholinguistic Abilities (ITPA): This is designed for children from 2.5 to 10 years of age. It has 12 subtests which can be grouped to form a profile of strengths and weaknesses. One grouping compares the child's visual versus auditory abilities. Further groupings divide abilities to assess how a child is receiving information, expressing himself, and what associations are taking place between input and output. A separate score is obtained on each subtest, as well as on the groupings, and a composite psycholinguistic

age is also given. Programs for remediation have been developed to be used in concert with the results of this test.

Test for Auditory Comprehension of Language (Carrow): Designed to assess a child's understanding of vocabulary, morphology (grammar), and syntax (language structure), the TACL is appropriate for children ages 3 to 6 years. It is available in Spanish and English versions and also has a screening form which can be used for group administration.

Northwestern Syntax Screening Test (NSST): This contains both receptive and expressive subtests. The NSST assesses development in the areas of understanding and use of grammatical structures. It is applicable to children ages 3 to 8 years.

Developmental Sentence Analysis (Lee): This analyzes the spontaneous language production of children. It provides information regarding pre-sentence structures, and the syntactic and morphologic forms of sentences of children ranging from 2 to 7 years. It estimates the child's level of expressive language development and provides guidelines for planning interventions.

Goldman-Fristoe-Woodcock Auditory Skills Test Battery: This assesses various aspects of auditory perceptual abilities, including memory, discrimination, attention, sound blending, and sound imitation. This test is appropriate for the age range from 3 years to adulthood. This assessment helps pinpoint a child's auditory strengths and weaknesses which may be related to speech and language acquisition and use.

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